STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED AT HOME HOSPICE-MOBILE	**2800 DAUPHIN STREET, SUITE 103** **MOBILE, AL 36606**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 520	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT This CONDITION is not met as evidenced by: This Condition level deficiency was cited based on review of agency policies, medical records and interviews with agency staff, it was determined the agency failed to ensure: 1. The Registered Nurse completed a comprehensive pain assessment for all patients. 2. Patients' Comprehensive Assessment Medication Profiles were up to date with the patients' current medications. 3. The Interdisciplinary Group was informed of changes in the patients condition and the patients' response to care. These deficient practices affected 10 of 19 records reviewed and had the potential to negatively affect all patients served by the hospice agency. Findings include: Refer to L521, L530 and L533 for findings.	L 520		
L 521	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related	L 521		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/20/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 521	Continued From page 1	L 521		

conditions.

This STANDARD is not met as evidenced by:
Based on review of agency policies, medical records (MR) and interviews with agency staff, it was determined the Registered Nurse (RN) failed to complete a comprehensive pain assessment for 1 of 19 records reviewed. This affected MR # 1 and had the potential to negatively affect all patients admitted to this agency.

Findings include:

Agency Policy: 03-04 Assessment and Reassessment
Revised: 12/14/15

Policy:
1. The Hospice will conduct and document a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice related to the palliation and management of the terminal illness and related conditions...

... 3. A Hospice Registered Nurse (RN) should complete an initial assessment and Plan of Care on the effective date of the election of the hospice benefit. The Assessment and Plan of Care will be consistent with the patient's and caregiver's immediate care needs...

... 7. The comprehensive assessment, at a minimum, will consider the following:

Condition causing admission...

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L 521	Continued From page 2 Severity of symptoms... 1. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer. Review of the Nursing Comprehensive Admission Assessment dated 4/14/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient. Review of the Comprehensive Assessment Medication Profile revealed the patient's pain medication included Tramadol 50 milligrams (mg) every 6 hours as needed (prn) with the date ordered 4/14/16. An interview was conducted on 5/20/16 at 10:10 AM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 3, who stated, "if the patient has no pain, the nurse does not have to complete the entire pain assessment."	L 521		
L 530	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions	L 530		

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(iv) Duplicate drug therapy
(v) Drug therapy currently associated with laboratory monitoring.

This STANDARD is not met as evidenced by:
Based on review of the medical records (MR), agency policy and interviews with the staff it was determined the agency failed to ensure all patients' Comprehensive Assessment Medication Profiles (MP) were up to date with the patients' current medications. This affected 10 of 19 MR's reviewed and did affect Home Visit (HV) # 3, MR # 2, MR # 3, MR # 5, HV # 2, MR # 11, MR # 9, HV # 1, HV # 4, MR # 13 and had the potential to negatively affect all patients served by the agency.

Findings include:

1. HV # 3 was admitted to the agency on 5/13/16 and recertified on 4/24/16 to 6/22/16 with admitting diagnoses of Cerebral Vascular Accident (CVA) with Cognitive Deficits Following CVA.

Review of the Physician Admission/Level of Care Orders dated 5/10/16 revealed an order for Oxygen (O2) at 2/l (liters) by nasal cannula (NC).

Review of the MP dated 4/19/16 revealed the O2 was not updated on the patient's MP.

Review of the Interdisciplinary Group (IDG) Meeting dated 5/17/16 in the pain management section revealed the skilled nurse (SN) documented the patient continues use of Ibuprofen.

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Continued From page 4

Review of the MP dated 4/19/16 revealed the nurse failed to add the Ibuprofen and up date the MP as needed.

A HV was conducted on 5/18/16 at 10:15 AM with Employee Identifier (EI) # 9, Hospice Aide, to observe care provided.

During the HV, the patient's medications were reviewed with the daughter using the patient's medication bottles and the MP provided to the surveyor by the agency.

The following medications were in the home and not on the MP dated 4/19/16:

Amlodipine 10 mg (milligrams) twice a day- started 5/9/16
Ibuprofen 400 mg TID (three times a day) - started 4/1/16

The following medications were listed on the MP and not in the home:

Colace 100 mg daily - stopped 4/1/16
Ativan 1 mg every 4 hours PRN (as needed)
Duoneb 0.5 - 2.5 mg/ml (milliliters) 1 ml per inhalation - stopped over a year ago.
Amitiza 24 mcg (micrograms) daily - stopped 4/16
Norco 7.5/325 mg 1 tablet every 8 hours PRN - stopped 4/16
Dulcolax 10 mg 1 suppository every 6 hours PRN - stopped 4/16
Sorbitol 70% 3 teaspoons(tsp) twice a day - caregiver stated stopped a long time ago but unsure of the date.
Triple Antibiotic 3.5/400-500 ointment topical PRN stopped months ago.

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An interview was conducted on 5/20/16 at 12:50 PM with Employee Identifier (EI) # 5, Manager of Clinical Practice (MCP) # 5, who confirmed the above mentioned findings.

2. MR # 2 was admitted to the agency on 4/12/16 with an admitting diagnosis of Alzheimer's Disease, Unspecified.

Review of the SN visit note dated 5/9/16 revealed the nurse documented in the narrative the MD was notified and an order was received to check for impaction and administer enema if needed.

Review of the MP dated 4/12/16 revealed no documentation the MP was updated with the enema and what type of enema was to be given.

Review of the Interdisciplinary Group (IDG) meeting dated 5/12/16 revealed the SN documented the patient was started on stool softeners.

Review of the MP dated 4/12/16 revealed no documentation the MP was updated with the stool softer.

An interview was conducted on 5/20/16 at 12:00 PM with EI # 3, MCP # 3, who confirmed the above mentioned findings.

3. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive.

Review of Hospice Initial Orders dated 4/22/16 revealed the following order: Synthroid 50 mcg 100 mcg (micrograms) 2 tablets every morning.

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Review of the physician order dated 4/22/16 revealed the following order for Oxygen: Provide Oxygen via NC at 2 - 4 l/min PRN.

Review of the SN visit note dated 4/23/16 revealed the SN documented in the narrative the caregiver gave the patient Benadryl to assist with sleep.

Review of the MP, which was provided to the surveyor on 5/17/16, revealed no documentation the MP was updated with the Oxygen, Synthroid or Benadryl.

An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings.

4. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia.

Review of the SN visit note dated 4/5/16 revealed the SN documented Thick it was ordered.

Review of the physician order dated 4/5/16 revealed an order for Oxygen 2 l/min per NC PRN.

Review of the physician order dated 4/14/16 revealed the following order: Roxanol 20 mg/ml give 0.5 - 1 ml every 2 hours PRN pain.

Review of the MP, which was provided to the surveyor on 5/17/16, revealed no documentation the MP was updated with Thick it, Oxygen and Roxanol.

An interview was conducted with EI # 2 who

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L 530	Continued From page 7 confirmed the above mentioned findings. 5. HV # 2 was admitted to the agency on 1/27/15 with diagnosis including Senile Dementia. This patient resides in a Skilled Nursing Facility (SNF). Review of the Interdisciplinary Plan of Care Review/Updates dated 3/23/16, 4/6/16, 4/13/16, 4/27/16 and 5/11/16 revealed no documentation the Interdisciplinary Group reviewed the patients medications. A HV was conducted on 5/18/16 at 10:00 AM with the Chaplain to observe care. During this HV, the surveyor reviewed the patient's Comprehensive Assessment Medication Profile, which was provided to the surveyor prior to the HV with the SNF Licensed Practical Nurse (LPN) assigned to the patient and the patient's medical records from the facility. The following medications were listed on the Comprehensive Assessment Medication Profile, but had been discontinued (D/C): Celexa 20 mg 1 tablet every day. (D/C 6/3/15) Meclizine 12.5 mg every 8 hours prn (D/C 6/3/15) Xyzal 5 mg 1/2 tablet at bed time (hs) (D/C 11/13/15) The following medications were on the SNF medical record, but not listed on the Comprehensive Assessment Medication Profile: Vitamin B 12 1000 mcg every day (Start date 10/9/15) Hydroxyzine 25 mg every 8 hours, prn Tylenol 325 mg (2) tablets three times a day, prn (Start date 11/13/15)	L 530		

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Q-Tussin 100 mg/5 ml every 4 hours, prn (Start date 1/13/16)
Tramadol - Acetaminophen 37.5 - 3 every 6 hours, prn (Start date 6/3/15)

An interview was conducted on 5/20/16 at 10:00 AM with EI # 4, MCP # 4, who stated there were no new orders in the hospice medical record.

6. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Physician Order dated 4/27/16 revealed orders to "Hold Coumadin today - 4/27/16, Restart Coumadin 2 mg every other day on 4/28/16. Review of the Comprehensive Assessment Medication Profile revealed no documentation of the Coumadin dosage change.

Review of the Physician Order dated 4/27/16 revealed orders for Coumadin dosage change to 2 mg five times a week. Review of the Comprehensive Assessment Medication Profile revealed no documentation of the Coumadin dosage change.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5, who verified the above findings.

7. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer. Review of the Physician Order dated 3/14/16 revealed an order for Nystatin Mouthwash 100000 units(u)/ml, 5 ml four times a day for 7 days.

Review of the Nursing Clinical Note dated 5/9/16 revealed the nurse documented the patient had rhonchi to the right lung, notified the physician and orders were received for Duoneb nebulizer

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treatments three times a day.

Review of the Comprehensive Assessment Medication Profile, which was printed for the surveyor on 5/17/16, revealed Nystatin was listed as a current medication, with no discontinue date and there was no documentation of Duoneb.

An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.

8. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2).

A HV was conducted on 5/17/16 at 1:45 PM to observe care provided by EI # 7 Medical Social Worker.

A medication review was completed utilizing the MP dated 5/9/16. The following medications were listed on the MP, but were not found in the home:

a. Atorvastatin Calcium 40 mg 1 tablet every night at bedtime.
b. Ferrous Gluconate 325 mg 1 tablet daily.

Further review of the MP revealed Gabapentin 100 mg 3 tablets three times per day. The medication bottle in the home had take 1 capsule three times per day.

During the HV, the patient was wearing oxygen at 3.5 L per minute which was not listed on the MP.

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L 530	Continued From page 10 An interview was conducted on 5/20/16 at 11:00 AM with EI # 6, MCP # 6, who verified the above findings. 9. HV # 4 was admitted to the agency on 11/16/15 and recertified for 2/14/16 to 5/13/16 with diagnoses including Hemiplegia Following Cerebral Infarction Affecting Non-Dominate Side, Aphasia and Hypertension. A HV was conducted on 5/18/16 at 1:45 PM to observe care provided by EI # 8, Registered Nurse. A medication review was completed utilizing the MP provided by the agency dated 5/2/16 and the medication bottles provided by the caregiver. The following medications were listed on the MP as current but were not in the home: a. Gabapentin 400 mg 2 caps (capsules) every night at bedtime. b. Sertraline HCL 50 mg 1 tab (tablet) daily. c. Iron 65 mg 1 tab daily. In addition, the patient takes Aspirin 81 mg 1 tablet daily which was not listed on the MP. The medication discrepancies were reviewed and confirmed with EI # 8 at the end of the home visit. 10. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor. Review of the MR revealed copied orders from the facility chart dated 4/15/16 to increase the H2O (water) flush to 240 ml Q (every) 4 hours.	L 530		

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L 530	Continued From page 11 Review of the MP dated 4/12/16 revealed an order to flush the tube with 200 ml of H2O every 4 hours and the new order dated 4/15/16 was not on the MP. Further review of the MP revealed an order dated 4/12/16 for Keflex 500 mg twice per day for 4 days remained on the current MP with no discontinue date. An interview was conducted on 5/20/16 at 11:35 AM with EI # 6 who verified the above findings.	L 530		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based on review of the medical records (MR) , agency policies and interviews with the staff, it was determined the agency failed to provide documentation at each Interdisciplinary Group (IDG) meeting for the changes in the patients condition and the patients' response to care in 10 of 19 medical records reviewed. This affected MR	L 533		

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L 533	Continued From page 12 # 3, MR # 5, MR # 14, MR # 7, MR # 10, Home Visit (HV) # 4, HV # 2, MR # 11, MR # 9 and MR # 8 and had the potential to negatively affect all patients served by the hospice agency. Findings include: Policy: Assessment and Reassessment Policy Number 03-04 Revised date: 12/14/15 Policy: 8. The comprehensive assessment and Plan of Care will be updated by the hospice interdisciplinary group (IDG) (in collaboration with the individual's attending physician, if any) and will consider changes that have taken place since the initial assessment. Updates will include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care... Policy: Interdisciplinary Group (IDG) Meeting Policy Number: 03-11 Revised Date: 12/14/15 Policy: 7. The IDG will ensure that: The care and services provided are based on all assessments of the patient and family needs. There is ongoing sharing of information among all disciplines providing care and services in all settings... 1. MR # 3 was admitted to the agency on 4/22/16	L 533		

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L 533	Continued From page 13 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive. Review of the Hospice Initial Order dated 4/22/16 revealed an order for Oxygen via NC (nasal cannula) at 2 - 4 l (liters)/ min (minute) PRN (as needed). Review of the SN visit note dated 4/23/16 revealed the nurse documented in the narrative section of the note the caregiver provided Benadryl to the patient for sleep. Review of the IDG meeting dated 4/28/16 revealed no documentation the Oxygen, nor the Benadryl was discussed in the meeting with the IDG team. Review of the SN visit notes dated 5/3/16 and 5/9/16 revealed the SN documented the patient had a swallowing deficit. Review of the IDG meeting dated 5/12/16 revealed no documentation of the patient having difficulty in swallowing under the nutrition/fluid maintenance/upper GI (Gastrointestinal) section of the meeting. An interview was conducted on 5/20/16 at 11:15 AM with Employee Indentifier # 2, Manager of Clinical Practice (MCP) # 2, who confirmed the above mentioned findings. 2. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia. Review of the SN visit note dated 4/5/16 the SN documented Thick it was ordered due to difficulty	L 533		

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L 533	Continued From page 14 in swallowing. Review of the physician order dated 4/5/16 revealed an order for Oxygen 2 l/min per NC PRN. Review of the physician order dated 4/14/16 revealed the following order: Roxanol 20 mg (milligrams)/ml (milliliters) give 0.5 - 1 ml every 2 hours PRN (as needed) pain. Review of the IDG meeting dated 4/14/16 revealed no documentation the Plan of Care was updated to meet the patient's needs. The SN failed to document in the IDG the patient's use of Thick it due to difficulty swallowing, the use of Oxygen as needed and the change in the patient's pain medication. An interview was conducted on 5/20/16 at 11:35 AM with EI # 2 who confirmed the above mentioned findings. 3. MR # 14 was admitted to the agency on 4/14/16 with an admitting diagnosis of Chronic Systolic (Congestive) Heart Failure. Review of the Nursing Comprehensive Admission Assessment visit note dated 4/14/16 revealed the patient had skin tears. Review of the SN visit notes dated 4/15/16, 4/18/16, 4/22/16, 4/25/16, 4/29/16, 5/4/16, 5/6/16 and 5/9/16 the nurse documented in the narrative section of the note the patient had a skin tear to the left leg. Further review of the SN visit note dated 5/6/16 the nurse documented the sitter will complete the dressing change after the bath.	L 533		

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L 533	Continued From page 15 Review of the SN visit note dated 4/16/16 the patient had trace edema to the lower extremities. Review of the SN note dated 4/18/16 the patient's edema increased to 2 + pitting edema. Review of the SN visit note dated 4/22/16 revealed the patient's edema increased to 3 + pitting edema to the lower extremities. Review of the SN visit note dated 4/25/16 the nurse documented the INR (International Normalized Ratio) was checked. Review of the IDG meetings dated 4/19/16, 5/3/16 and 5/17/16 revealed no documentation the IDG team was updated on the patient's change in condition. The nurse failed to document the change in the patient's edema, teaching and return demonstration of wound care by the caregiver and the sitter. The nurse also failed to document INR blood draws were being obtained every 2 weeks. An interview was conducted on 5/20/16 at 12:30 PM with EI # 6, MCP # 6, who confirmed the above mentioned findings. 4. HV # 4 was admitted to the agency on 11/16/15 and recertified for 2/14/16 to 5/13/16 with diagnoses including Hemiplegia Following Cerebral Infarction Affecting Non-Dominate Side, Aphasia and Hypertension. Review of the IDG Updates dated 3/8/16 and 3/22/16 revealed documentation under Functional Status the Hospice Aide assists with ADLs (Activities of Daily Living). MR review revealed the Hospice Aide service was no longer provided per	L 533		

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L 533	Continued From page 16 caregiver request. An interview was conducted on 5/20/16 at 11:25 AM with EI # 1, MCP # 1, who verified the Plan of Care was not updated appropriately. 5. MR # 7 was admitted to the agency on 1/14/16 with diagnoses including Pancreatic Cancer with Liver Metastasis. Review of the IDG Update dated 2/2/16 revealed the following medication changes since the last IDG: Ativan, Reglan, Roxanol, and Promethazine. There was no documentation by the IDG regarding the reason for the new medications, what symptoms the patient was experiencing nor documentation of the effectiveness of the medications. Further review of the IDG dated 2/2/16 revealed Knowledge Deficit was not addressed in the POC. Review of the IDG Update dated 2/16/16 revealed the following medication changes since the last IDG: Morphine ER (Extended Release) bid (twice a day), Phenergan and Atropine Sulfate. There was no documentation by the IDG regarding the reason for the new medications, what symptoms the patient was experiencing nor documentation of the effectiveness of the medications. Further review of the IDG dated 2/16/16 revealed Knowledge Deficit was not addressed in the POC. An interview was conducted on 5/20/16 at 11:45 AM with EI # 6, MCP # 6, who confirmed the above mentioned findings.	L 533		

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6. MR # 10 was admitted to the agency on 4/1/16 with diagnoses including End Stage Renal Disease, Chronic Inflammatory Demyelinating Polyneuropathy, and Hypertension.

Review of the Nursing Comprehensive Admission Assessment dated 4/1/16 revealed the patient was determined to be a high fall risk.

Review of the IDG Plan of Care Review/Updates dated 4/13/16, 4/20/16 and 5/4/16 revealed the Safety/Falls care plan had not been initiated.

Review of the IDG Update dated 4/20/16 revealed for each open care plan the nurse documented "continue to assess POC and change plan as needed". There was no documentation of discussion by the IDG of the problems identified during assessments nor whether the interventions implemented by the IDG were effective.

An interview was conducted on 5/20/16 at 11:45 AM with EI # 4, MCP # 4, who confirmed the above mentioned findings.

7. HV # 2 was admitted to the agency on 1/27/15 with diagnosis including Senile Dementia. This patient resides in a Skilled Nursing Facility (SNF).

Review of the Interdisciplinary Plan of Care Review/Updates dated 3/23/16, 4/6/16, 4/13/16, 4/27/16 and 5/11/16 revealed no documentation the Interdisciplinary Group reviewed the patient's medications.

A HV was conducted on 5/18/16 at 10:00 AM with the Chaplain to observe care. During this HV, the surveyor reviewed the patient's Comprehensive

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Assessment Medication Profile, which was provided to the surveyor prior to the HV with the SNF Licensed Practical Nurse (LPN) assigned to the patient and the patient's medical records from the facility.

The following medications were listed on the Comprehensive Assessment Medication Profile, but had been discontinued (D/C):

Celexa 20 mg 1 tablet every day. (D/C 6/3/15)
Meclizine 12.5 mg every 8 hours prn (D/C 6/3/15)
Xyzal 5 mg 1/2 tablet at bed time (hs) (D/C 11/13/15)

The following medications were on the SNF medical record, but not listed on the Comprehensive Assessment Medication Profile:

Vitamin B 12 1000 micrograms (mcg) every day (Start date 10/9/15)
Hydroxyzine 25 mg every 8 hours, prn
Tylenol 325 mg (2) tablets three times a day, prn (Start date 11/13/15)
Q-Tussin 100 mg/5 milliliters (ml) every 4 hours, prn (Start date 1/13/16)
Tramadol - Acetaminophen 37.5 - 3 every 6 hours, prn (Start date 6/3/15)

An interview was conducted on 5/20/16 at 10:00 AM with EI # 4, MCP, who stated there were no new orders in the hospice medical record and the Comprehensive Assessment Medication Profile was not updated.

8. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia.

Review of the Nursing Comprehensive Admission

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Assessment dated 4/2/16 revealed the patient had a Stage 1 decubitus to the sacral area, which measured 1 centimeter (cm) by 1 cm. Further review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed, additional orders included; barrier cream to reddened area on sacrum daily and prn (as needed). There was no documentation the nurse performed wound care to the area.

Review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed volunteer and pre-bereavement services were explained and accepted. Further review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed the patient was using Oxygen (O2) at 2 liters (L)/minute (min) continuous.

Review of the Nursing Clinical notes revealed the nurse also visited the patient on 4/3/16, 4/5/16 and 4/8/16, which was 4 times the week of 4/2/16.

Review of the Nursing Clinical Note dated 4/3/16 revealed the patient had a non-productive cough and was using O2 at 2 L/min.

Review of the Physician Order dated "Late entry" for 4/5/16 revealed orders to cleanse Stage 1 decubitus to coccyx with wound cleanser, pat dry, apply barrier cream. Caregiver to perform after each incontinent episode.

Review of the Nursing Clinical Note dated 4/5/16 revealed the nurse applied a thick layer of barrier cream to the coccyx decubitus. The nurse failed to provide wound care according to the physician's order above.

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Further review of the Nursing Clinical Note dated 4/5/16 revealed the nurse performed a fingerstick INR and the patient had a cough at night was using O2 prn.

Review of the Social Work (SW) Comprehensive Assessment dated 4/6/16 revealed the SW documented, "... SW to discuss with IDG (Interdisciplinary Group) team about having the dietician make a visit..." There was no documentation in the medical record the dietician visited or called the patient/caregiver.

Review of the initial Interdisciplinary Plan of Care (POC) dated 4/12/16 revealed no documentation in the Nutrition/Fluid Maintenance/Upper GI (Gastrointestinal) plan that the dietician was addressed by the IDG. Review of the Interdisciplinary POC dated 4/12/16 revealed no documentation the volunteer services was ordered. Further review revealed the visit frequency for Skilled Nursing (SN) and Bereavement Coordinator (BC) was 1 time a week for 1 week beginning the week of 4/2/16.

There was no documentation of visits by the volunteer or BC. The 4 SN visits for the week of 4/2/16 were not reflected in the Interdisciplinary POC dated 4/12/16.

Review of the Nursing Clinical Note dated 4/8/16 revealed the nurse documented the patient's decubitus to the coccyx area was a Stage 2, which measured 0.5 cm by 0.5 cm. The nurse further documented having cleansed the area with wound cleanser, patted dry and covered with Hydrocolloid dressing. Further review of the Nursing Clinical Note dated 4/8/16 revealed the patient continued to have a cough at night and

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was using O2 prn.

Review of the Interdisciplinary POC dated 4/12/16 revealed the plan for integumentary was initiated on 4/2/16, the "Problem" was not identified. The "Goals" included, "Skin integrity will remain unaltered... Pt/CG (patient/caregiver) will verbalize understanding of how altered skin status is affected by disease process". The "Interventions" included, "Assess skin integrity every visit" assigned to the Skilled Nurse (SN) and Hospice Aide (HA) and "Teach Pt/CG relationship between disease process and skin integrity". The "Plan" was, "Continue same intervention(s)".

There was no documentation on the Interdisciplinary POC the patient had a decubitus to the sacrum or coccyx areas, nor was there documentation of the wound care interventions the nurse was performing as documented above. Further review of the Interdisciplinary POC dated 4/12/16 revealed no documentation of the INR via fingerstick or that the patient had a cough or was using O2.

Review of the Physician Order dated 4/27/16 revealed orders to "Hold Coumadin today - 4/27/16, Restart Coumadin 2 mg every other day on 4/28/16. Review of the Comprehensive Assessment Medication Profile revealed no documentation of the Coumadin dosage change.

Review of the Physician Order dated 4/27/16 revealed orders for Coumadin dosage change to 2 mg five times a week. Review of the Comprehensive Assessment Medication Profile revealed no documentation of the Coumadin dosage change.

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L 533	Continued From page 22 Review of the Interdisciplinary POC Review/Update dated 5/3/16 revealed no documentation the patient was taking Coumadin. An interview was conducted on 5/20/16 at 12:25 AM with EI # 5, MCP # 5, who verified the above findings. 9. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer. Review of the Physician Order dated 3/14/16 revealed an order for Nystatin Mouthwash 100000 units(u)/ml, 5 ml four times a day for 7 days. Review of the Nursing Clinical Note dated 3/28/16 revealed the nurse documented the patient had a skin tear to the mid-back, which measured 2.0 cm (centimeters) by 2.5 cm by 0.1 cm and performed wound care to the area. There was no documentation of the specific wound care provided. Review of the Physician Order dated 3/28/16 revealed orders to cleanse the skin tear to the mid-back with wound cleanser, pat dry, apply wound gel, cover with Xeroform gauze, secure with non-stick dressing, weekly per SN (Skilled Nurse) or CG (caregiver). Review of the Interdisciplinary POC Review/Update dated 3/29/16 revealed new interventions for the skin tear to the patient's back were Bacitracin, non-stick dressing. Review of the Nursing Clinical Note dated 4/4/16 revealed the nurse documented the patient had a	L 533		

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L 533	Continued From page 23 new skin tear to the left hand, which measured 2.0 cm by 1.5 cm. Review of the Physician Order dated 4/4/16 revealed orders to cleanse skin tear to left hand with wound cleanser, pat dry, apply wound gel, cover with non-stick dressing, two times a week per SN or CG. Review of the Interdisciplinary POC Review/Update dated 4/12/16 revealed, "... Plan: Continue same intervention(s)..." There was no documentation the POC had been updated to reflect the new skin tear to the left hand or interventions. Review of the Nursing Clinical Note dated 5/2/16 revealed the nurse documented, "... Pt (patient) does not have arrangements made, requested MSW (Medical Social Worker) for guidance... Physician contacted... request for MSW...: Review of the Interdisciplinary POC review/Update dated 5/3/16 revealed no documentation of the patient/caregiver request for MSW. There were no documented visit frequencies for the Social Worker (SW) and there was no documentation of a visit or phone call from the SW. Review of the Nursing Clinical Note dated 5/9/16 revealed the nurse documented the patient had rhonchi to the right lung, notified the physician and orders were received for Duoneb nebulizer treatments three times a day. Review of the Interdisciplinary POC Review/Update dated 5/17/16 revealed no documentation of the patient's rhonchi or the	L 533		

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L 533	Continued From page 24 addition of Duoneb treatments three times a day. An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings. 10. MR # 8 was admitted to the agency on 3/14/16 with diagnosis including Senile Dementia. Review of the initial Nursing Comprehensive Admission Assessment dated 3/14/16 revealed the nurse documented the patient had a Stage 2 pressure ulcer to the sacral area. There was no documentation of the size of the pressure ulcer, nor was there documentation of nursing interventions or teaching of the care of this pressure ulcer. Review of the Interdisciplinary Plan of Care (POC), which was electronically signed by the Interdisciplinary Group (IDG) on 3/23/16 revealed Knowledge Deficit was initiated as a concern with the intervention of "Skin/wound care" and to continue same interventions. There was no documentation of the specific skin/wound care interventions for this patient's stage 2 pressure ulcer to the sacrum. An interview was conducted on 5/20/16 at 10:40 AM with EI # 3, MCP # 3, who verified the above findings.	L 533		
L 536	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES This CONDITION is not met as evidenced by: This Condition level deficiency was cited based on review of agency policies, medical record	L 536		

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L 536	Continued From page 25 review, and interviews with agency staff, it was determined the agency failed to ensure: 1. The visit frequency was followed by each discipline providing care as established in the Plan of Care. 2. Teaching and education was provided to the caregivers as needed for wound care and newly ordered medication. 3. The Interdisciplinary Group developed an individualized plan of care, interventions or goals for each patient, including psychosocial issues, pain, terminal diagnoses, wound care and tube feedings. 4. The plan of care included orders for wound care, Oxygen and laboratory testing. 5. The physician was notified with changes in patients' conditions. These deficient practices affected 16 of 19 charts reviewed and had the potential to negatively affect all patients admitted to this agency. Findings include: Please refer to findings at L543, L544, L545, L549 and L557.	L 536		
L 543	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or	L 543		

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representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.

This STANDARD is not met as evidenced by:
Based on review of agency policies, medical record (MR) review, and interviews with agency staff it was determined the agency failed to ensure the visit frequency was followed by each discipline providing care as established in the Plan of Care (POC) affecting 9 of 19 records reviewed. The deficient practice affected Home Visit (HV) # 1, MR # 4, MR # 2, MR # 3, MR # 5, HV # 2, MR # 1, MR # 11, MR # 9 and had the potential to affect all patients served by the agency.

Findings include:

Policy 03-12 Plan of Care
Revised 12/14/15

Policy
1. All hospice care and services furnished to patients and their families must follow an individualized written Plan of Care established by the Hospice Interdisciplinary Group (IDG) in collaboration with the attending physician (if any), the patient or designated legal representative, and the primary caregiver in accordance with the patient's needs...

Policy 03-11 Interdisciplinary Group Meeting
revised 12/14/15

Policy
7. The IDG will ensure that...The care and services are provided in accordance with the Plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011605	A. BUILDING ____ B. WING ____	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED AT HOME HOSPICE-MOBILE	2800 DAUPHIN STREET, SUITE 103 MOBILE, AL 36606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 543	Continued From page 27 of Care. 1. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2). Review of the IDG POC Review/Updates dated 3/22/16, 4/5/16 and 4/13/16 revealed the Spiritual Care Coordinator was to visit 2 x (times) per month. There was no documentation a second visit was conducted during the months of March and April. An interview was conducted on 5/20/16 at 11:00 AM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, who confirmed there was no second visit by the Chaplain for March and April. 2. MR # 4 was admitted to the agency on 4/12/16 with diagnoses including Heart Failure Unspecified, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease. Review of the IDG POC dated 4/14/16 revealed the Hospice Aide (HA) was to visit 3 x per week beginning the week of 4/12/16. Review of the HA visit notes for the week of 4/12/16 revealed only 2 visits dated 4/14/16 and 4/16/16. An interview was conducted on 5/20/16 at 12:40 PM with EI # 3, MCP # 3, who confirmed there was no third visit by the HA for the week of 4/12/16.	L 543		

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L 543	Continued From page 28	L 543		

3. MR # 2 was admitted to the agency on 4/12/16 with an admitting diagnosis of Alzheimer's Disease, Unspecified.

Review of the IDG dated 4/21/16 revealed a frequency of visit for the SN (Skilled Nurse) 1 time a week for 1 week to start 4/12/16. Review of the IDG dated 4/28/16 revealed a frequency of visit for the SN as 1 time a week for 2 weeks starting 5/8/16. Review of the IDG dated 5/12/16 revealed a frequency of visit for the SN as 2 times a week for 2 weeks starting 5/22/16.

Review of the SN visit notes dated 4/12/16 to 5/16/16 revealed the SN made 1 visit the weeks of 4/17/16 and 4/24/16 and the week of 5/1/16 the SN made 2 visits that week.

Review of all of the IDG Review/Updates revealed no documentation of orders for the SN visits conducted for the above mentioned 3 weeks.

An interview was conducted on 5/20/16 at 12:00 PM with EI # 3, MCP # 3, who confirmed the above mentioned findings.

4. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive.

Review of the IDG meeting dated 4/28/16 revealed the frequency for the SN as follows: 1 time a week for 1 week starting 4/22/16, then 1 time a week for 2 weeks starting 5/1/16. Review of the IDG dated 5/12/16 revealed the frequency of visits for the SN was 2 times a week for 1 week starting 5/9/16 and then 1 time a week for 1 week

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L 543	Continued From page 29	L 543		

starting 5/15/16.

Review of all the frequency of visit documentation revealed no visits ordered for the week of 4/24/16. The SN made 2 visits that week and did not follow the written frequency by the IDG.

An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings.

5. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia.

Review of the IDG meeting dated 4/14/16 revealed the frequency of visits for the SN were as follows: 1 time a week for 2 weeks starting 4/4/16. Review of the IDG meeting dated 4/28/16 revealed the frequency of visits for the SN were 1 time a week for 2 weeks starting 5/1/16. Review of the IDG meeting dated 5/12/16 revealed the frequency of visits for the SN were 2 times a week for 2 weeks starting 5/2/16 and then 2 times a week for 1 week starting 5/15/16.

Review of all of the IDG Review/Updates revealed no documentation of orders for the SN visits conducted for the weeks of 4/17/16 and 4/24/16.

An interview was conducted on 5/20/16 at 11:35 AM with EI # 2, who confirmed the above mentioned findings.

6. HV # 2 was admitted to the agency on 1/27/15 with diagnosis including Senile Dementia. Review of the Interdisciplinary POC Review/Update dated 3/23/16 revealed the scope/frequency of visits for

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L 543	Continued From page 30 the SN was to visit 1 time a week for 1 week. Review of the medical record revealed no documentation the SN visited the patient the week of 3/27/16. An interview was conducted on 5/20/16 at 10:00 AM with EI # 4, MCP # 4, who verified the above findings. 7. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer. Review of the initial Interdisciplinary POC dated 4/28/16 revealed the Scope/Frequency of visits for the Spiritual Care Coordinator (SCC) were 1 time a week for 1 week beginning the week of 4/14/16. Review of the medical record revealed no documentation of SCC visits. An interview was conducted on 5/20/16 at 10:10 AM with EI # 3, MCP # 3, who verified the above. 8. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed volunteer and pre-bereavement services were explained and accepted. Review of the Nursing Clinical notes revealed the nurse also visited the patient on 4/3/16, 4/5/16 and 4/8/16, which was 4 times the week of 4/2/16. Review of the Social Work (SW) Comprehensive	L 543		

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Assessment dated 4/6/16 revealed the SW documented, "... SW to discuss with IDG team about having the dietician make a visit..." There was no documentation in the medical record the dietician visited or called the patient/caregiver.

Review of the initial Interdisciplinary POC dated 4/12/16 revealed no documentation in the Nutrition/Fluid Maintenance/Upper GI (Gastrointestinal) plan that the dietician was addressed by the IDG. Review of the Interdisciplinary POC dated 4/12/16 revealed no documentation the volunteer services were ordered. Further review revealed the visit frequency for SN and Bereavement Coordinator (BC) were 1 time a week for 1 week beginning the week of 4/2/16.

There was no documentation of visits by the volunteer or BC. The 4 SN visits for the week of 4/2/16 were not reflected in the Interdisciplinary POC dated 4/12/16.

Review of the Interdisciplinary POC review/Update dated 5/3/16 revealed the visit frequency for the SN was 2 times a week beginning the week of 5/1/16.

Review of the Nursing Clinical Notes for the week of 5/1/16 revealed the SN visited the patient on 5/4/16. There was no documentation of a second visit for the week of 5/1/16.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5, who verified the above findings.

9. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer.

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L 543 — L 543

Continued From page 32

Review of the Nursing Clinical Note dated 5/2/16 revealed the nurse documented, "... Pt (patient) does not have arrangements made, requested MSW (Medical Social Worker) for guidance... Physician contacted... request for MSW...:

Review of the Interdisciplinary POC review/Update dated 5/3/16 revealed no documentation of the patient/caregiver request for MSW. There were no documented visit frequencies for the SW and there was no documentation of a visit or phone call by the SW.

An interview was conducted on 5/20/16 at 100:50 AM with EI # 4, MCP # 4, who verified the above findings and there was no documentation of SW visits.

L 544 — L 544

418.56(b) PLAN OF CARE

The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

This STANDARD is not met as evidenced by:
Based on review of the medical records (MR), agency policy and interviews with the staff, it was determined the agency failed to provide teaching and education to the caregiver and sitters as needed for wound care and newly ordered medication. This affected 7 of 19 charts reviewed and did affect MR # 14, MR # 11, MR # 9, MR # 12, MR # 7, Home Visit (HV) # 1, HV # 4 and had the potential to negatively affect all patients served by the agency.

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Findings include:

Policy: Plan of Care
Policy Number: 03/12
Revised Date: 12/14/15

Policy:
4. The Hospice must ensure that each patient and the primary caregiver(s) receive education and training provided by the Hospice as appropriate to their responsibilities for the care and services identified in the Plan of Care (POC).

1. MR # 14 was admitted to the agency on 4/14/16 with an admitting diagnosis of Chronic Systolic (Congestive) Heart Failure.

Review of the Nursing Comprehensive Admission Assessment visit note dated 4/14/16 revealed the patient had skin tears.

Review of the SN (Skilled Nurse) visit notes dated 4/15/16, 4/18/16, 4/22/16, 4/25/16, 4/29/16, 5/4/16, 5/6/16 and 5/9/16 the nurse documented in the narrative section of the note the patient had a skin tear to the left leg.

Further review of the SN visit note dated 5/6/16 the nurse documented the sitter will complete the dressing change after the bath.

Review of all the SN visit notes and the IDG meetings dated 4/19/16, 5/3/16 and 5/17/16 revealed no documentation the SN completed teaching to the caregiver or the sitter on how to perform the ordered wound care and no documentation of a return demonstration.

An interview was conducted on 5/20/16 at 12:30

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L 544	Continued From page 34 PM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, confirmed the above mentioned findings. 2. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed the patient had a stage I decubitus to the sacral area, which measured 1 centimeter (cm) by 1 cm. Further review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed, additional orders included; barrier cream to reddened area on sacrum daily and prn (as needed). There was no documentation the nurse performed wound care to the area or instructed the caregiver on the use of barrier cream. Review of the Nursing Clinical Note dated 4/3/16 revealed no documentation the nurse performed wound care or instructed the caregiver on the use of barrier cream. Review of the Nursing Clinical Note dated 4/5/16 revealed the nurse applied a thick layer of barrier cream to the coccyx (sacrum) decubitus. There was no documentation the nurse instructed the caregiver on the use of barrier cream. Review of the Physician Order dated "Late entry" for 4/5/16 revealed orders to cleanse stage I decubitus with wound cleanser, pat dry, apply barrier cream. Caregiver to perform after each incontinent episode. There was no documentation the nurse instructed the caregiver on the physician ordered wound care. An interview was conducted on 5/20/16 at 12:25	L 544		

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L 544	Continued From page 35 PM with EI # 5, MCP # 5, who verified the above findings. 3. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer. Review of the Nursing Clinical Note dated 3/28/16 revealed the nurse documented the patient had a skin tear to the mid-back, which measured 2.0 cm by 2.5 cm by 0.1 cm and performed wound care to the area. There was no documentation of the specific wound care provided, nor was there documentation teaching was provided to the patient's caregiver, of wound care to be provided, infection control measures or signs/symptoms of infection. An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings. 4. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2). Review of the Nursing Clinical Note dated 4/13/16 revealed the patient had a deep, wet sounding cough and orders were obtained for new medications Z-Pack and Medrol Dose Pack. There was no documentation of medication instructions for these 2 new medications. An interview was conducted on 5/20/16 at 11:00 AM with EI # 6, MCP # 6, who verified there was no documentation the nurse instructed on the new medications.	L 544		

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5. HV # 4 was admitted to the agency on 11/16/15 and recertified for 2/14/16 to 5/13/16 with diagnoses including Hemiplegia Following Cerebral Infarction Affecting Non-Dominate Side, Aphasia and Hypertension.

Review of the Nursing Clinical Note dated 2/15/16 revealed a new wound to the left calf. The physician was contacted and wound care orders were received to cleanse the wound with wound cleanser, pat dry, apply wound gel, cover with non-stick dressing, and change every 3 days and as needed. The nurse visit frequency was 1 time per week. There was no documentation the caregiver was given instructions on the wound care procedure and no documentation a return demonstration was observed.

An interview was conducted on 5/20/16 at 11:25 AM with EI # 1, MCP # 1, who verified there was no documentation of teaching nor that a return demonstration was observed.

6. MR # 7 was admitted to the agency on 1/14/16 with diagnoses including Pancreatic Cancer with Liver Metastasis.

Review of the Nursing Clinical Note dated 2/9/16 revealed the patient started Roxanol. There was no documentation of specific instructions provided to the patient or caregiver regarding the Roxanol dosage and administration, potential side effects and actions, and signs and symptoms to report.

An interview was conducted on 5/20/16 at 11:45 AM with EI # 6, MCP # 6, who verified there was no documentation of specific teaching related to

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L 544	Continued From page 37 the Roxanol. 7. MR # 12 was admitted to the agency on 4/1/16 with diagnoses including Congestive Heart Failure. Review of the Nursing Clinical Note dated 4/14/16 revealed the patient was experiencing chest pain 2-3 times per week. There was no documentation of instructions by the nurse regarding management of the chest pain. Review of the Nursing Clinical Note dated 4/21/16 revealed the patient was experiencing chest pain 2-3 times per week and numbness to the left arm. There was no documentation of instructions by the nurse regarding management of the chest pain and numbness to the left arm. Review of the Nursing Clinical Note dated 4/28/16 revealed the patient was experiencing chest pain 2-3 times per day and dizziness daily. There was no documentation of instructions by the nurse regarding management of the patients symptoms. Review of the Nursing Clinical Note dated 5/5/16 revealed the patient had a severe problem with dizziness and chest pain 1-2 times per week. There was no documentation of instructions by the nurse regarding management of the dizziness and chest pain. Review of the Nursing Clinical Note dated 5/12/16 revealed the patient had periorbital edema, dizziness all the time, and chest pain 2-3 times per week. There was no documentation of instructions by the nurse regarding management of the edema, dizziness or the chest pain.	L 544		

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L 544	Continued From page 38 An interview was conducted on 5/20/16 at 12:15 PM with EI # 5, MCP # 5, who verified the above mentioned findings.	L 544		
L 545	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on review of agency policies, medical records (MR) and interviews with agency staff, it was determined the Interdisciplinary Group (IDG) failed to develop an individualized plan of care, interventions or goals for each patient, including psychosocial issues, pain, terminal diagnoses, wound care and tube feedings. This affected 3 of 19 records reviewed, including MR # 6, MR # 12 and MR # 13 and had the potential to affect all patients served by the agency. Findings include: Agency Policy: 03-11 Interdisciplinary Group (IDG) Meeting Revised: 12/14/2015 Policy: 1. In accordance with 418.56, the Interdisciplinary	L 545		

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Group (IDG), in consultation with the attending physician, must coordinate a written Plan of Care for each patient. The plan must specify the hospice care and services necessary to meet the patient and family needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions...

... 7. The IDG will ensure that:

The care and services are provided in accordance with the Plan of Care.

The care and services provided are based on all assessments of the patient and family needs...

Agency Policy: 03-12 Plan of Care
Revised: 12/14/2015

Policy:

1. All hospice care and services furnished to patients and their families must follow an individualized written Plan of Care (POC) established by the Hospice Interdisciplinary Group (IDG) in collaboration with the attending physician (if any), the patient or designated legal representative, and the primary caregiver in accordance with the patient's needs if any of then so desire.

2. Prior to the provision of care, the admitting Registered Nurse (RN), in collaboration with the Hospice Medical Director, IDG, and admitting physician (if any), will establish an individualized Plan of Care for each patient admitted to the Hospice program...

... The Plan of Care must:

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... Include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

Interventions to manage pain and symptoms

A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs

Measurable outcomes anticipated from implementing and coordinating the Plan of Care

Drugs and treatment necessary to meet the needs of the patient...

1. MR # 6 was admitted to the agency on 4/15/16 with diagnoses including Malignant neoplasm of tonsilar fossa, Secondary malignant neoplasm of right lung, liver, intrahepatic bile duct and brain.

Review of the Interdisciplinary Hospice Communication - Intake Note dated 4/15/16, which was not timed, but electronically signed by Employee Identifier (EI) # 15, Registered Nurse (RN) Manager of Clinical Practice (MCP) # 7 at 1:52 PM revealed, "Referral received from (physician) regarding the admission of (MR # 6)... with tonsilar cancer, that has pain concerns... also living in an environment with drug diversion concerns. (Physician's nurse) voiced the patient has been discharged from two other hospices for cause and they were seeking help for a hospice willing to manage hospice care..."

Review of the Nursing Comprehensive Admission Assessment dated 4/15/16 revealed no documentation the nurse identified problems with

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the patient's living conditions related to potential drug diversion.

Review of the Interdisciplinary Hospice Communication - Intake Note dated 4/16/16 at 4:00 PM revealed the Licensed Practical Nurse (LPN) documented that she arrived at the patient's home and there was no answer at the door. The nurse documented neighbors informed her the patient had been taken to the hospital by ambulance which she reported to the (RN) Registered Nurse.

Review of the Interdisciplinary Hospice Communication - Intake Note dated 4/16/16 at 5:00 PM revealed the above mentioned RN documented the LPN attempted to visit the patient, but the patient had gone to the Emergency Department (ED). The RN documented she called the ED and spoke with the nurse, who stated the patient came in with pain. The nurse stated the patient was given pain prescriptions and the ED was sending the patient home.

Review of the Nursing Clinical Note dated 4/17/16 revealed this was a prn (as needed) visit due to the patient having been seen in the ER. During this nursing visit, the patient had a pain rated 10 on a 0-10 scaled (0 being no pain, 10 being severe pain). The nurse documented the patient had not taken any doses of prn/breakthrough pain medications in the last 24 hours and "... pt (patient) has no pain meds (medications) currently... nods that (he/she) is in pain and is tearful, holding... abdomen... able to say "my back"... shakes head "no" when asked where (his/her) pain meds are that (he/she) got from ED yesterday. I called (his/her) cousin and he doesn't

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L 545	Continued From page 42 know where they are either. I left messages for other friends and family to call me as I am trying to locate meds. I called pharmacies to no avail. Will continue to try and locate meds... Pt seems confused... Educated pt on calling Hospice if... needs something and nodded..." Review of the Interdisciplinary Hospice Communication - Pharmacy/DME (Durable Medical Equipment) note dated 4/17/16 at 8:45 PM revealed the RN documented having picked up medications from the pharmacy, delivered them to the patient and instructed on use. Review of the Interdisciplinary Hospice Communication - Pharmacy/DME note dated 4/17/16 at 9:00 PM, revealed the above mentioned RN documented having delivered (6) Dilaudid 4 milligram (mg) tablets, (6) Percocet 10 mg tablets and 50 milliliters (ml) Phenergan solution. Review of the Social Work (SW) Comprehensive Assessment dated 4/18/16 revealed the SW documented the patient was weak and in pain, has a lack of supportive relationships and history of substance (predominantly alcohol) issues. The SW documented the patient's neighbors steal the patient's medications/wallet and the patient's medication has to be monitored closely as the patient lives in an unsafe neighborhood. The patient is eager to go to a nursing home (NH) so he/she doesn't have to worry about missing medications. The SW documented NH placement is being coordinated. The SW documented encourage/assist the patient with community agencies for social/financial support with specific goals documented to coordinate long term care in a NH as soon as possible. Review of the Interdisciplinary Hospice	L 545		

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L 545	Continued From page 43 Communication - Phone Contact dated 4/18/16 at 3:00 PM revealed the RN documented she had received multiple phone calls from the patient, who had left messages. The RN documented having called the patient, who stated he/she was going to a "home" today and needs help. The patient stated he/she was out of pain medication and was in a lot of pain. The RN documented the patient was at home alone and was unable to manage medications. Review of the Nursing Clinical Note dated 4/18/16 revealed the RN documented the patient had pain rated 7 out of 10, the patient's pain medications were stolen and replacement of the patient's medications were in progress. The RN documented the on call nurse would deliver the pain medications, to take pain medications as ordered and to put the medications up, if he had visitors. The patient stated that he/she would. Review of the Interdisciplinary Hospice Communication - Pharmacy/DME note dated 4/18/16 at 6:55 PM revealed the RN documented having picked up the patient's medications from the pharmacy, she and the LPN made a joint delivery of (10) tablets (undocumented medication) to the patient's home. Review of the initial Interdisciplinary Plan of Care dated 4/19/16 revealed interventions for the patient's psychosocial well-being were documented, but, the plan was not implemented, there were no identified problems or goals. The documented comments included, "... Pt needs a safer living environment and SW/SN (Skilled Nurse) will be coordinating NH placement ASAP (as soon as possible)..."	L 545		

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Further review of the Interdisciplinary Plan of Care dated 4/19/16 revealed no documentation of the patient's ED visit, lack of pain medications or the issues with staff having to deliver the patient's pain medications were discussed or a plan implemented until such time NH placement could be found.

An interview was conducted on 5/20/16 at 10:25 AM with Employee Identifier (EI) # 5, Manager of Clinical Practice (MCP) # 5, who verified the above.

2. MR # 12 was admitted to the agency on 4/1/16 with diagnoses including Congestive Heart Failure.

Review of the IDG Plan of Care dated 4/6/16 and 4/13/16 revealed no documentation goals were identified for care of the cardiopulmonary system.

Review of the IDG Update dated 4/20/16 and 5/4/16 revealed documentation the patient was having chest pain 2-3 times per week. There was no documentation of discussion or plans by the IDG to manage this pain.

An interview was conducted on 5/20/16 at 12:15 PM with EI # 5, MCP # 5, who verified there were no goals documented for the cardiopulmonary system and there was no documentation of interventions to manage the patient's chest pain.

3. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor. The patient was a resident of a nursing facility.

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L 545	Continued From page 45 Review of the Nursing Comprehensive Admission Assessment revealed a Stage 1 pressure ulcer to the left heel that measured L (length) 2 cm (centimeters), W (width) 1.5 cm, and D (depth) 0 cm; an Unstageable pressure wound to the left medial foot that measured L 0.5 cm, W 4 cm, D 0.3 cm with purulent drainage; and a Stage 2 pressure ulcer to the the right lateral foot that measured L 2 cm, W 2 cm, and D 0 cm. Review of the Nursing Clinical Note dated 4/13/16 revealed documentation the patient was receiving tube feedings of Diabetisource at 75 cc/hr (cubic centimeters/per hour). Review of the Hospice Initial Order dated 4/12/16 and the Initial IDG Plan of Care dated 4/20/16 revealed no order for wound care, nor for the tube feeding. Further review of the IDG Updates dated 4/20/16 and 5/4/16 revealed Pain Management with interventions and goals was not initiated for this patient who was bed bound, contracted, had wounds and had Norco 7.5/325 mg ordered for pain. An interview was conducted on 5/20/16 at 11:35 AM with EI # 6, MCP # 6, who confirmed the above mentioned findings.	L 545		
L 549	418.56(c)(4) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the needs of the patient.	L 549		

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This STANDARD is not met as evidenced by:
Based on medical record (MR) review and interviews with agency staff, it was determined the plan of care did not include a plan for wound care, Oxygen (O2) or laboratory testing orders for 3 of 19 records reviewed. This affected MR # 8, MR # 11, MR # 9, Home Visit (HV) # 4 and had the potential to negatively affect all patients admitted to the hospice.

Findings include:

1. MR # 8 was admitted to the agency on 3/14/16 with diagnosis including Senile Dementia.

Review of the initial Nursing Comprehensive Admission Assessment dated 3/14/16 revealed the nurse documented the patient had a Stage 2 pressure ulcer to the sacral area. There was no documentation of the size of the pressure ulcer, nor was there documentation of nursing interventions or teaching of the care of this pressure ulcer.

Review of the Interdisciplinary Plan of Care (POC), which was electronically signed by the Interdisciplinary Group (IDG) on 3/23/16 revealed Knowledge Deficit was initiated as a concern with the intervention of "Skin/wound care" and to continue same interventions. There was no documentation of the specific skin/wound care interventions for this patient's stage 2 pressure ulcer to the sacrum.

An interview was conducted on 5/20/16 at 10:40 AM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 2, who verified the

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L 549	Continued From page 47 above findings. 2. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed the patient had a Stage 1 decubitus to the sacral area, which measured 1 cm by 1 cm. Further review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed, additional orders included; barrier cream to reddened area on sacrum daily and prn (as needed). Further review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed the patient was using O2 at 2 liters (L)/minute (min) continuous. Review of the Nursing Clinical Note dated 4/3/16 revealed the patient had a non-productive cough and was using O2 at 2 L/min. Review of the Physician Order dated "Late entry" for 4/5/16 revealed orders to cleanse Stage 1 decubitus to coccyx with wound cleanser, pat dry, apply barrier cream. Caregiver to perform after each incontinent episode. Review of the Nursing Clinical Note dated 4/5/16 revealed the nurse performed a fingerstick INR (International normalized ratio) and the patient had a cough at night was was using O2 prn. Review of the Nursing Clinical Note dated 4/8/16 revealed the nurse documented the patient's decubitus to the coccyx area was a Stage 2, which measured 0.5 cm by 0.5 cm. The nurse further documented having cleansed the area	L 549		

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L 549		L 549		

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with wound cleanser, patted dry and covered with Hydrocolloid dressing.

Further review of the Nursing Clinical Note dated 4/8/16 revealed the patient continued to have a cough at night and was using O2 prn.

Review of the Interdisciplinary POC dated 4/12/16 revealed the plan for integumentary was initiated on 4/2/16, the "Problem" was not identified. The "Goals" included, "Skin integrity will remain unaltered... Pt/CG (patient/caregiver) will verbalize understanding of how altered skin status is affected by disease process". The "Interventions" included, "Assess skin integrity every visit" assigned to the Skilled Nurse (SN) and Hospice Aide (HA) and "Teach Pt/CG relationship between disease process and skin integrity". The "Plan" was, "Continue same intervention(s)".

There was no documentation on the Interdisciplinary POC the patient had a decubitus to the sacrum or coccyx areas, nor was there documentation of the wound care interventions the nurse was performing as documented above. Further review of the Interdisciplinary POC dated 4/12/16 revealed no documentation of the INR via fingerstick or that the patient had a cough or was using O2.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5, who verified the above findings.

3. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer. Review of the Physician Order dated 3/28/16 revealed orders to cleanse the skin tear to the mid-back with wound

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L 549	Continued From page 49 cleanser, pat dry, apply wound gel, cover with Xeroform gauze, secure with non-stick dressing, weekly per SN or CG. Review of the Nursing Clinical Note dated 3/28/16 revealed the nurse documented the patient had a skin tear to the mid-back, which measured 2.0 cm by 2.5 cm by 0.1 cm and performed wound care to the area. There was no documentation of the specific wound care provided. Review of the Interdisciplinary POC Review/Update dated 3/29/16 revealed new interventions for the skin tear to the patient's back were Bacitracin and a non-stick dressing. Review of the Nursing Clinical Note dated 3/30/16 revealed the nurse documented having performed wound care to the patient's skin tear to the mid-back. There was no documentation of the specific wound care provided. Review of the Nursing Clinical Note dated 4/2/16 revealed the nurse documented having performed wound care to the patient's skin tear to the mid-back as follows, "... wound cleansed and I placed vaseline gauze with 4 x 4 gauze with paper tape over it to avoid sticking..." There was no documentation of what the nurse used to cleanse the wound. The nurse also failed to follow the POC utilizing Bacitracin and non-stick dressing. Review of the Physician Order dated 4/4/16 revealed orders to cleanse skin tear to left hand with wound cleanser, pat dry, apply wound gel, cover with non-stick dressing, two times a week per SN or CG.	L 549		

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L 549	Continued From page 50 Review of the Nursing Clinical Note dated 4/7/16 revealed the nurse documented having performed wound care to the patient's skin tear to the left hand as follows, "... wound gel applied covered with non-stick dressing, secured with paper tape..." and to the mid-back as follows, "... skin tear cleansed with wound cleanser, patted dry, applied wound gel, covered with non-stick dressing..." There was no documentation the nurse cleansed the skin tear to the left hand with wound cleanser prior to the application of wound gel and dressing. The nurse also failed to follow the POC for wound care to the mid-back utilizing Bacitracin and non-stick dressing. Review of the Interdisciplinary POC Review/Update dated 4/12/16 revealed, "... Plan: Continue same intervention(s)..." There was no documentation the POC had been updated to reflect the new skin tear to the left hand or interventions. Review of the Nursing Clinical Note dated 4/13/16 revealed the nurse documented having performed wound care to the patient's skin tear to the left hand as follows, "... wound gel applied, covered with non-stick dressing and secured with paper tape..." and to the mid-back as follows, "... skin tear covered for protection..." There was no documentation the nurse cleansed the skin tear to the left hand prior to the application of wound gel and the dressing, nor was there documentation the nurse performed wound care to the mid-back utilizing Bacitracin and non-stick dressing. Review of the Nursing Clinical Note dated 4/18/16 revealed the nurse documented having performed wound care to the patient's skin tear to	L 549		

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L 549	Continued From page 51	L 549		

the left hand as follows, "... wound gel applied, covered with non-stick dressing, secured with paper tape..." The dressing to the patient's back was documented as being clean, dry and intact. There was no documentation the nurse cleansed the skin tear to the left hand prior to the application of wound gel and the dressing.

Review of the Interdisciplinary POC Review/Update dated 4/19/16 revealed, "... Plan: Continue same intervention(s)... Comments: Skin tear to back and left hand healing with current tx (treatment). Monitor efficacy and s/s (signs/symptoms) infection Q (every) visit..."

An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.

4. HV # 4 was admitted to the agency on 11/16/15 and recertified for 2/14/16 to 5/13/16 with diagnoses including Hemiplegia Following Cerebral Infarction Affecting Non-Dominate Side, Aphasia and Hypertension.

Review of the Nursing Clinical Note dated 2/27/16 revealed the patient had skin tears to the left upper leg, which were cleaned and steri strips and Bacitracin ointment was applied.

Review of the physician's order dated 2/29/16 revealed an order to cleanse the skin tears with skin cleanser, pat dry, apply steri strips to close wound, leave in place until healed. There was no order for the Bacitracin ointment.

An interview was conducted on 5/20/16 at 11:25 AM with EI # 1, MCP # 1, who verified there was no order for the Bacitracin ointment.

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L 557	418.56(e)(4) COORDINATION OF SERVICES	L 557		

[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]
(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

This STANDARD is not met as evidenced by:
Based on review of medical records (MR), agency policy and interviews with the staff, it was determined the agency failed to ensure all disciplines notified the physician with changes in the patient's condition. This affected 4 of 19 MR's reviewed and did affect MR # 2, MR # 3, MR # 5, and MR # 14 and had the potential to negatively affect all patients served by the agency.

Findings include:

Policy Assessment and Reassessment
Policy Number: 03-04
Revised Date: 12/14/15

Policy:

8. The comprehensive assessment and Plan of Care will be updated by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and will consider changes that have taken place since the initial assessment. Updates will include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment

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and Plan of Care update will be accomplished as frequently as the condition of the patient requires, but no less that every 15 days.

9. Updated of the comprehensive assessment will consider at a minimum:

The patient's diagnosis and disease process
The patient's pain and other symptoms...

...Evaluation of interventions and services established in the Plan of Care...

1. MR # 2 was admitted to the agency on 4/12/16 with an admitting diagnosis of Alzheimer's Disease, Unspecified.

Review of the SN (Skilled Nurse) visit note dated 5/4/16 revealed in the narrative the patient (pt) was having decreased bowel sounds during the assessment, caregiver stated the pt had some nausea, vomiting and continued to be very pale in color and decreased loc (level of conciseness) and not talking, patient checked and stomach was slightly distended... rectal exam done and pt is very full with hard stool, manual removal of hard BM (bowel movement) noted... and the SN documented she increased the pt's Lactulose to 3 times daily.

Further review of the narrative section of the note and IDG (Interdisciplinary Group) meetings dated 4/21/16, 4/28/16 and 5/12/16 revealed no documentation the physician was notified of the patient's change in the patient's condition or that new orders were received by the physician.

Review of the SN visit note dated 5/4/16 at 9:15 PM, which was an on call visit, the nurse

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L 557	Continued From page 54 documented "the patient gets enemas freq (frequently) for constipation. Further review revealed no documentation the physician was notified of the constipation or that the patient was receiving enemas. Review of the SN visit note dated 5/5/16 revealed the nurse documented in the narrative "...patient continue to have increased amounts of BM in rectal and remains unable to push out, pt given mineral oil enema and rectal exam done medium amount of stool removed..." Further review of the narrative section revealed no documentation the physician was notified of patients condition or an order was received for the mineral oil enema. An interview was conducted on 5/20/16 at 12:00 PM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 3, who confirmed the above mentioned findings. 2. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive. Review of the SN visit notes dated 4/29/16, 5/3/16, 5/11/16 and 5/13/16 the SN documented under the GU (genitourinary) section of the note the patient has swallowing deficits. Further review of the notes revealed no documentation the physician was notified in the change in the patient's condition. An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings. 3. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular	L 557		

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Accident (CVA), Hypertension and Dementia.

Review of the SN visit note dated 4/7/16 revealed the SN documented in the narrative section of the note " He is choking on liquids easily so thickener was ordered". Further review of the note revealed no documentation the physician was notified of the patient's change in condition or that the physician gave the order for the thickener.

SN visit note dated 4/7/16 revealed the SN documented in the narrative section of the note the patient had pain in the morning and was diaphoretic and that the patient's urine had a strong odor. Further review of the SN visit note revealed no documentation the physician was notified of the change in the patient's condition only that orders were received.

SN visit note dated 4/15/16 revealed the SN documented the patient had a decrease in functional status and that an order was received for Roxanol. Further review of the SN visit note revealed no documentation the physician was notified of the change in the patient's condition and no documentation the patient was having pain.

Review of the SN visit note dated 5/13/16 revealed the SN documented in the narrative section of the note the patient continues to lean more when he/she is in the chair due to poor trunk control. The SN also documented received an order to increase Trazadone. Further review of the SN visit note revealed no documentation the physician was notified of the patients increase in leaning while in a chair and the patient's difficulty with sleeping.

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L 557	Continued From page 56 An interview was conducted on 5/20/16 at 11:35 AM with EI # 2 who confirmed the above mentioned findings. 4. MR # 14 was admitted to the agency on 4/14/16 with an admitting diagnosis of Chronic Systolic (Congestive) Heart Failure. Review of the SN visit note dated 4/16/16 the cardiovascular assessment revealed the patient only had trace edema to the bilateral lower extremities. Review of the SN visit note dated 4/18/16 revealed the patient had 2 + pitting edema to the lower extremities. Further review of the note revealed no documentation the physician was notified in the increase of edema in 2 days. Review of the SN visit note dated 4/22/16 revealed the patient's edema is now rated a 3+ pitting edema to the bilateral feet which has increased from a 2+ pitting edema to a 3+ edema in 4 days. Further review of the SN visit note revealed no documentation the physician was notified in the increase in the patient's edema which is a change in the patient's condition. Review of the IDG meetings dated 4/19/16, 5/3/16 and 5/17/16 revealed no documentation by the Registered Nurse (RN) of the increased in edema to the patient's bilateral lower extremities. An interview was conducted on 5/20/16 at 12:30 PM with EI # 6, MCP # 6, who confirmed the above mentioned findings.	L 557		
L 591	418.64(b)(1) NURSING SERVICES	L 591		

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L 591	Continued From page 57 (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. This STANDARD is not met as evidenced by: Based on review of agency policies, Alabama Board of Nursing Administrative Code, medical records (MR) and interviews with agency staff, it was determined the nursing staff failed to complete a comprehensive assessment for pain, nausea/vomiting and wounds. This affected 8 of 19 medical records reviewed, including MR # 6, MR # 8, MR # 1, MR # 11, MR # 9, MR # 7, MR # 13, MR # 2 and had the potential to negatively affect all patients admitted to this hospice. Findings include: Agency Policy: 03-04 Assessment and Reassessment Revised: 12/14/15 Policy: 1. The Hospice will conduct and document a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice related to the palliation and management of the terminal illness and related conditions... ... 3. A Hospice Registered Nurse (RN) should complete an initial assessment and Plan of Care	L 591		

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on the effective date of the election of the hospice benefit. The Assessment and Plan of Care will be consistent with the patient's and caregiver's immediate care needs...

... 7. The comprehensive assessment, at a minimum, will consider the following:

Condition causing admission...

Severity of symptoms...

8. The comprehensive assessment and Plan of Care will be updated by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and will consider changes that have taken place since the initial assessment. Updates will include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment and Plan of Care update will be accomplished as frequently as the condition of the patient requires, but no less that every 15 days.

9. Updated of the comprehensive assessment will consider at a minimum:

The patient's diagnosis and disease process
The patient's pain and other symptoms...

...Evaluation of interventions and services established in the Plan of Care...

Agency Policy:

A review of the Wound Care - Assessment & Documentation Components of a Complete Wound Assessment policy revealed general

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assessment criteria as it relates to location, size, appearance, wound tissue type(s), surrounding skin and drainage. This policy does not address the frequency for performing complete wound assessments.

Alabama Board of Nursing Administrative Code Chapter 610-x-6

610-X-6-.06 Documentation Standards.
(1) The standards for documentation of nursing care provided to patients by registered nurses and licensed practical nurses are based on principles of documentation regardless of the documentation format.

(2) Documentation of nursing care shall be:

(a) Legible.
(b) Accurate.
(c) Complete. Complete documentation includes reporting and documenting on appropriate records a patient's status, including signs and symptoms, responses, treatments, medications, other nursing care rendered, communication of pertinent information to other health team members, and unusual occurrences involving the patient. A signature of the writer, whether electronic or written, is required in order for the documentation to be considered complete.

610-X-6-.09 Assessment Standards.
(1) Patient assessment shall be provided in accordance with the definitions of professional nursing and practical nursing as defined in the Alabama Nurse Practice Act, Section 34-21-1.

(2) The registered nurse shall conduct and

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document comprehensive and focused nursing assessments of the health status of patients by:

(a) Collecting objective and subjective data from observations, physical examinations, interviews and written records in an accurate and timely manner as appropriate to the patient's health care needs.

(b) Analysis and reporting of data collected.

(c) Developing plan of care based upon the patient assessment.

(d) Modifying the plan of care based upon the evaluation of patient responses to the plan of care, including:

(i) Anticipating and recognizing changes or potential changes in patient status.

(ii) Identifying signs and symptoms of deviation from current health status.

(iii) Implementing changes in interventions.

(3) The licensed practical nurse shall conduct and document focused nursing assessments of the health status of patients by:

(a) Collecting objective and subjective data from observations, nursing examinations, interviews and written records in an accurate and timely manner as appropriate to the patient's health care needs.

(b) Distinguishing abnormal from normal data.

(c) Recording, and reporting the data.

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(d) Anticipating and recognizing changes or potential changes in patient status; identifying signs and symptoms of deviation from current health status.

(e) Reporting findings of the focused nursing assessment to the registered nurse, licensed physician, advanced practice nurse, or dentist.

(f) Implementing the plan of care.

1. MR # 6 was admitted to the agency on 4/15/16 with diagnoses including Malignant neoplasm of tonsilar fossa, Secondary malignant neoplasm of right lung, liver, intrahepatic bile duct and brain.

Review of the Interdisciplinary Hospice Communication - Intake Note dated 4/15/16, which was not timed, but electronically signed by Employee Identifier (EI) # 15, Registered Nurse (RN) Manager of Clinical Practice (MCP) # 7 at 1:52 PM revealed, "Referral received from (physician) regarding the admission of (MR # 6)... with tonsilar cancer, that has pain concerns... also living in an environment with drug diversion concerns. (Physician's nurse) voiced the patient has been discharged from two other hospices for cause and they were seeking help for a hospice willing to manage hospice care..."

Review of the Nursing Comprehensive Admission Assessment dated 4/15/16 revealed the patient's pain was uncomfortable because of pain, rated 8 on 0-10 scale (0 being no pain, 10 being severe pain) with the patient's acceptable pain level of 3 on 0-10 scale. The patient's pain was located in the mid back area with a severity rating of 10 (0-10 scale). The nurse further documented the

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patient complained of pain all over. The nurse documented the patient has Soma and Norco and the patient's Dilaudid pump was discontinued today (4/15/16) and the patient had just taken pain medication since coming home from the doctor. The patient verified he/she takes breakthrough pain medication 2 to 3 times a day.

Review of the Interdisciplinary Hospice Communication - Intake Note dated 4/16/16 at 5:00 PM revealed the RN documented the LPN attempted to visit the patient, but the patient had gone to the Emergency Department (ED). The RN documented she called the ER and spoke with the nurse, who stated the patient came in with pain. The nurse stated the patient was given pain prescriptions and the ED was sending the patient home.

Review of the Nursing Clinical Note dated 4/17/16 revealed this was a prn (as needed) visit due to the patient having been seen in the ED. During this nursing visit, the patient had a pain rated 10 on a 0-10 scale (0 being no pain, 10 being severe pain). There was no documentation of a complete assessment of the patient's pain, including worst/best the pain gets or acceptable pain level for the patient, pain history and treatment including breakthrough pain medications or the amount of breakthrough pain medications taken in the last 24 hours. The nurse documented "... pt (patient) has no pain meds (medications) currently... nods that (he/she) is in pain and is tearful, holding... abdomen... able to say "my back"... shakes head "no" when asked where (his/her) pain meds are that (he/she) got from ED yesterday. I called (his/her) cousin and he doesn't know where they are either. I left messages for other friends and family to call me as I am trying

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to locate meds. I called pharmacies to no avail. Will continue to try and locate meds... Pt seems confused... Educated pt on calling Hospice if... needs something and nodded..."

Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/18/16 at 3:00 PM revealed the RN documented she had received multiple phone calls from the patient, who had left messages. The RN documented having called the patient, who stated he/she was going to a "home" today and needs help. The patient stated he/she was out of pain medication and was in a lot of pain. The RN documented the patient was at home alone and was unable to manage medications.

Review of the Nursing Clinical Note dated 4/18/16 revealed the RN documented the patient had pain rated 7 out of 10, the patient's pain medications were stolen and replacement of the patient's medications were in progress. There was no documentation a complete assessment of the patient's pain, including the best pain gets or acceptable pain level for the patient. There was no documentation of an assessment of the pain history and treatment including breakthrough pain medications or the amount of breakthrough pain medications taken in the last 24 hours. The RN documented the on call nurse would deliver the pain medications, to take pain medications as ordered and to put the medications up, if he had visitors. The patient stated that he/she would.

Review of the initial Interdisciplinary Plan of Care dated 4/19/16 revealed no documentation of the patient's ED visit, lack of pain medications or the issues with staff having to deliver the patient's pain medications were discussed or a plan

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implemented to address those issues.

Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/19/16 at 2:45 PM revealed the RN documented she had received calls again on her work cell phone, the patient was upset, "needs help" and she called the office to notify them. There was no documentation of telephone contact or that a nurse visit was conducted on 4/19/16 for the patient's complaints of "needs help".

Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/20/16 at 7:13 PM revealed the RN documented the patient was out of pain medications and was in severe pain and had not taken pain medications since that morning.

Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/20/16 at (undocumented time) revealed the RN documented the patient received two prescriptions for pain medications, one on 4/18 for 10 and it was delivered by on call personnel, another prescription on 4/19/16 for 20 pills of Norco 10. The RN documented she made another visit to the patient on 4/20/16 at 1:30 PM because he/she called stating was still hurting. The nurse documented she counted the medications at that time and the patient had 9 pills. The RN documented she received another call at around 4:00 PM from the patient's cousin, who stated the patient was completely out of medication. The RN documented, she had just left the patient and he/she had 9 pills left. The patient's cousin verbalized understanding and asked what were they going to do about the patient and medication. The RN documented she

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called administration and a decision was made that the patient would be ok until the morning. The RN documented she educated the patient about proper medication administration and that he/she needed to be careful about putting medication up because, she didn't think they would be able to get another prescription before being transported to the Long Term Care (LTC) facility (in the morning).

Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/20/16 at 8:15 PM revealed the RN documented the patient's friend had called service with patient in pain. The patient's medication prescription was sent to the pharmacy from the physician and a cousin of the patient was willing to pick them up, she informed the pharmacy and contacted the cousin to let him know to call if the patient gets worse or if they needed assistance and where to pick up the medications.

An interview was conducted on 5/20/16 at 10:25 AM with Employee Identifier (EI) # 5, Manager of Clinical Practice (MCP) # 5, who verified the above.

2. MR # 8 was admitted to the agency on 3/14/16 with diagnosis including Senile Dementia.

Review of the initial Nursing Comprehensive Admission Assessment dated 3/14/16 revealed the nurse documented the patient had a Stage 2 pressure ulcer to the sacral area. There was no documentation of the size of the pressure ulcer, nor was there documentation of nursing interventions.

Review of the Nursing Clinical Note dated 3/15/16

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L 591	Continued From page 66 revealed no documentation of an assessment of the above mentioned pressure ulcer. Further review of the Nursing Clinical Note dated 3/15/16 revealed the nurse documented the "Type of standardized pain screen tool used" included, "... Numeric, Verbal descriptor and Staff Observation". The numeric pain assessment revealed no documentation of the worst the pain gets, best the pain gets, pain level acceptable to patient or who the rated the patient's pain (Pt - patient, Caregiver or Hospice Nurse). An interview was conducted on 5/20/16 at 10:40 AM with EI # 3, MCP # 3, who verified the above findings. 3. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer. Review of the Comprehensive Assessment Medication Profile revealed the patient's pain medication included Tramadol 50 milligrams (mg) every 6 hours as needed (prn) with the date ordered 4/14/16. Review of the Nursing Clinical Note dated 4/15/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient. There was no documentation if the patient was taking breakthrough pain medications or the amount of breakthrough pain medications the patient had taken in the last 24 hours. Review of the Nursing Clinical Note dated 4/18/16 revealed the nursing assessment indicated the patient was not uncomfortable because of	L 591		

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L 591	Continued From page 67 pain,including worst/best and acceptable levels of pain for the patient. The nurse documented the patient takes Tramadol as needed, but stated he/she does not like to take pain medications. There was no documentation if the patient had taken breakthrough pain medications or the amount of breakthrough pain medications the patient had taken in the last 24 hours. Review of the Nursing Clinical Note dated 4/21/16 revealed the nursing assessment indicated the patient rated pain at "0" on 0 to 10 scale (0 being no pain and 10 severe pain). The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient. There was no documentation if the patient was taking breakthrough pain medications or the amount of breakthrough pain medications the patient had taken in the last 24 hours. Review of the Nursing Clinical Note dated 4/28/16 revealed the nursing assessment indicated the patient rated pain at "0" on 0 to 10 scale. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient. Review of the Nursing Clinical Note dated 5/3/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient. Review of the Nursing Clinical Note dated 5/12/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not	L 591		

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	011605	A. BUILDING ______ B. WING ______	05/20/2016

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L 591	Continued From page 68 completed for this patient, including worst/best and acceptable levels of pain for the patient. There was no documentation if the patient was taking breakthrough pain medications or the amount of breakthrough pain medications the patient had taken in the last 24 hours. Review of the Physician Order dated 5/12/16 revealed orders for Roxanol 20 milligrams (mg)/ milliliter (ml) 0.5 ml - 1 ml every 2 hours - pain. There was no documentation in the above nursing assessments of an increase in pain or an increase in the patient taking breakthrough pain medications requiring the addition of Roxanol for pain. An interview was conducted on 5/20/16 at 10:10 AM with EI # 3, MCP # 3, who stated, "if the patient has no pain, the nurse does not have to complete the entire pain assessment." 4. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Nursing Comprehensive Admission Assessment dated 4/2/16 revealed the patient had a Stage 1 decubitus to the sacral area, which measured 1 centimeter (cm) by 1 cm. Review of the Nursing Clinical Note dated 4/3/16 revealed no documentation of an assessment of the Stage 1 decubitus to the sacral area. Review of the Nursing Clinical Note dated 4/5/16 revealed the patient had a Stage 1 decubitus to the coccyx. There was no documentation of the measurements, tissue or drainage. There was no documentation of an assessment of the Stage 1 decubitus to the sacral area.	L 591		

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L 591	Continued From page 69	L 591		

Continued From page 69

The surveyor was unable to determine if the Stage 1 to the coccyx was the same decubitus as the above mentioned Stage 1 to the sacral area.

Review of the Nursing Clinical Note dated 4/8/16 revealed the nurse documented the patient's decubitus to the coccyx area was a Stage 2, which measured 0.5 cm by 0.5 cm. There was no documentation of an assessment of the Stage 1 decubitus to the sacral area.

Review of the Nursing Clinical Notes dated 4/20/16, 4/22/16, 4/27/16 and 5/4/16 revealed the patient had a Stage 2 decubitus to the coccyx. There was no documentation of the measurements, wound bed color, tissue or drainage. There was no documentation of an assessment of the Stage 1 decubitus to the sacral area.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5, who verified the above findings.

5. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer.

Review of the Nursing Clinical Notes dated 3/14/16, 3/17/16, 3/24/16, 3/28/16 (PM visit), 4/2/16, 4/4/16, 4/7/16, 4/18/16, 4/22/16, 4/25/16, 4/28/16 and 5/2/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient.

Review of the Nursing Clinical Note dated 5/2/16

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L 591	Continued From page 70	L 591		

revealed the nursing assessment indicated the patient was not uncomfortable because of pain, present pain was rate 2 on 0 - 10 scale. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient. The nurse further documented the patient showed more non-verbal signs/symptoms when repositioned and declined Norco (pain medication) more than once daily. There was no documentation of the non-verbal signs/symptoms of pain. A physician's order was obtained for an increase in Decadron and Roxanol (pain medication), even though there was no documentation the patient was experiencing increased pain.

Review of the Nursing Clinical Notes dated 5/4/16, 5/9/16, 5/12/16, 5/13/16 and 5/15/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient, including worst/best and acceptable levels of pain for the patient.

Review of the Nursing Clinical Note dated 5/15/16 revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The comprehensive pain assessment was not completed for this patient, including present pain level, worst/best and acceptable levels of pain for the patient. The pain history and treatment revealed the patient's breakthrough pain medication was Roxanol 10-20 mg, prn (as needed). There was no documentation of the amount and frequency the patient required breakthrough pain medication.

Review of the Nursing Clinical Note dated 5/16/16

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L 591	Continued From page 71	L 591		

revealed the nursing assessment indicated the patient was not uncomfortable because of pain. The patient's present pain level was "2" on 0-10 scale. There was no documentation who rated the patient's pain (patient, caregiver or hospice nurse). The comprehensive pain assessment was not completed for this patient, including present pain level, worst/best and acceptable levels of pain for the patient. There was no documentation of an assessment of non-verbal signs/symptoms of pain.

An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.

8. MR # 2 was admitted to the agency on 4/12/16 with an admitting diagnosis of Alzheimer's Disease, Unspecified.

Review of the SN visit note dated 4/27/16 revealed under the pain assessment section the nurse documented for the question " Are you uncomfortable because of Pain"? yes. Under signs of pain was documented "tense". Documentation under the type of standardized pain screen tool used: "Staff Observation".

Review of the comprehensive pain assessment and present level of pain sections of the note revealed the sections were blank. The SN failed to complete the pain assessment and follow up and document if the patient had taken pain medication as ordered.

Review of the SN visit note dated 5/4/16 revealed the SN documented under the question "Are you uncomfortable because of pain"? The SN documented "yes".

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L 591	Continued From page 72	L 591		

Further review of the pain assessment and level of pain sections revealed the SN failed to complete these sections and failed to document if the patient had taken pain medication prior to the visit.

An interview was conducted on 5/20/16 at 12:00 PM with EI # 3, MCP # 3, who confirmed the above mentioned findings.
6. MR # 7 was admitted to the agency on 1/14/16 with diagnoses including Pancreatic Cancer with Liver Metastasis.

Review of the Hospice Initial Order dated 1/14/16 revealed the patient was on Fentanyl Transdermal 50 mcg/hr (micrograms per hour) and Norco 10 - 325 mg (milligrams) every 4 hours prn for pain.

Review of the Nursing Comprehensive Admission Assessment dated 1/14/16 revealed the pain assessment failed to document the patient's acceptable pain level, worst pain gets, best pain gets, the location and character of the pain, pain worsened by, pain relieved by, effect on function or quality of life, associated symptoms and no documentation of the number of doses of Norco required in the last 24 hour period.

Review of the Nursing Clinical Note dated 1/15/16 revealed the patient's present pain level was 1 on a 0-10 scale (with 0 being no pain and 10 the worst pain) with a report of pain at 10 on 1/14/16. There was no documentation of the location and character of the pain, the duration and frequency of the pain, nor its effect on function and quality of life and associated symptoms.

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L 591	Continued From page 73 Review of the Nursing Clinical Note dated 2/9/16 revealed documentation the patient started taking Roxanol (liquid morphine) for pain. The nurse contacted the physician and orders were obtained for Morphine ER (extended release) regimen and discontinue the Duragesic (Fentanyl) patch. Further review of the Nursing Clinical Note dated 2/9/16 revealed the patient's pain was rated as 2 on a 0-10 scale. There was no documentation of the location and character of the pain, the duration and frequency of the pain, nor its effect on function and quality of life and associated symptoms. Review of the Nursing Clinical Note dated 2/11/16 revealed the patient was taking MSIR (Morphine Sulfate Immediate Release) Q (every) 4 hours and Morphine ER bid (twice a day) for pain. Further review revealed the patient had taken 4 prn doses in the last 24 hours. Further review of the note dated 2/11/16 revealed instruction to calculate the 24 hour total Morphine equivalent if 3 or more prn doses were required. There was no documentation of the total 24 hour Morphine equivalent. Review of the Nursing Clinical Note dated 2/16/16 revealed documentation the patient did not sleep much due to vomiting throughout the night. There was no documentation regarding medication assessment for nausea, the use of Zofran as ordered, its effectiveness or not, and no documentation the physician was notified. Review of the Nursing Clinical Note dated 2/18/16 revealed documentation the patient had been awake for the past 24 hours with nausea and	L 591		

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L 591	Continued From page 74	L 591		

vomiting. There was no documentation regarding medication assessment for nausea, the use of Zofran and/or Promethazine as ordered and its effectiveness or not for symptom management.

An interview was conducted on 5/20/16 at 11:45 AM with EI # 6, MCP # 6, who confirmed the above mentioned findings.

7. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor.

Review of the Nursing Comprehensive Admission Assessment revealed a Stage 1 pressure ulcer to the left heel that measured L (length) 2 cm (centimeters), W (width) 1.5 cm, and D (depth) 0 cm; an Unstageable pressure wound to the left medial foot that measured L 0.5 cm, W 4 cm, D 0.3 cm with purulent drainage; and a Stage 2 pressure ulcer to the the right lateral foot that measured L 2 cm, W 2 cm, and D 0 cm.

Review of all the nursing notes from 4/13/16 to 5/13/16 revealed no documentation of wound assessments or measurements.

Further review of all the nursing notes from 4/13/16 to 5/13/16 revealed documentation in the pain assessment section the patient answered "no" to the question "are you uncomfortable because of pain" and there was no documentation regarding how often the patient received Norco for pain.

The medical record review documentation revealed the patient was non-verbal, therefore unable to answer "yes" or "no".

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L 591	Continued From page 75 Review of the Nursing Clinical Note dated 4/19/16 revealed documentation the facility wound nurse requested a low air loss mattress due to skin deterioration. There is no documentation the hospice nurse assessed the patient's skin for deterioration. An interview was conducted on 5/20/16 at 11:35 AM with EI # 6, MCP # 6, who confirmed the hospice nurse did not document complete wound, pain and skin assessments.	L 591		
L 607	418.76 HOSPICE AIDE AND HOMEMAKER SERVICES This CONDITION is not met as evidenced by: This Condition level deficiency was cited based on review of agency policy and procedures, medical records, personnel files, Hospice Aide Assignment sheet example, Hospice Aide Visit Note example and interviews with agency staff, it was determined the agency failed to ensure: 1. The Hospice Aide (HA) was competent to provide care. 2. The HA Assignment was individualized to meet the specific needs of each patient. 3. The HA followed the Plan of Care. 4. The HA failed to notify the Registered Nurse (RN) for changes in the patients' condition. 5. The HA was supervised by the RN every 14 days and the RN supervisory visits were not	L 607		

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L 607	Continued From page 76 conducted prior to the initiation of HA services. These deficient practices affected 10 of 12 records review of patients receiving HA services. Findings include: Refer to L615, L625, L626, L628 and L629 for findings.	L 607		
L 615	418.76(c)(1) COMPETENCY EVALUATION An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient. This STANDARD is not met as evidenced by: Based on review of agency policy and procedures, personnel files and interviews with agency staff, it was determined the agency failed to ensure each Hospice Aide (HA) was competent to provide care affecting 3 of 4 HA personnel files reviewed. This affected Employee Identifier (EI) # 11, # 12, and # 13 and had the potential to affect all patients receiving hospice aide services. Findings include:	L 615		

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L 615		L 615		

Continued From page 77

Policy 07-08
Orientation and Competency Validation for Hospice Aides

Policy
4. Hospice aides must successfully complete a written competency evaluation and observed skills validation that includes all of the components required by federal regulations...
5. All hospice aides will demonstrate initial and annual competency...

General Information
4. All skills demonstrations must be completed on or before any patient visit or assignment during which those skills will be used and are on behalf of the hospice.

1. EI # 11, Hospice Aide, was hired by the agency on 2/24/14.

Review of the Skills Demonstration Checklist for Hospice Aide dated 2/28/14 revealed the following skills sections were blank:

Bed Bath
Sponge, tub, and shower bath
Hair Shampoo (bed, sink, and tub)
Toileting and Elimination: Urinal or Bedpan
Transfer Techniques
Normal Range of Motion (active-passive)
Foley Care
Empty Foley Bag
Feeding
Bed Making (occupied-unoccupied)
Safety Belt (if applicable)
Mechanical Lift (if applicable)

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L 615	Continued From page 78	L 615		

Further review of the personnel file for EI # 11 revealed no documentation of an annual skills validation. A request was made by the surveyor for documentation of an annual skills validation, but was not provided.

An interview conducted on 5/20/16 at 12:00 PM with EI # 1, Manager of Clinical Practice (MCP) # 1, verified the above findings.

2. EI # 12, Hospice Aide was hired by the agency on 8/25/14.

Review of the Skills Demonstration Checklist for Hospice Aide dated 9/10/14 revealed the following skills were blank:

Sponge, tub and shower bath
Hair Shampoo (bed, sink and tub)
Ambulation (cane - walker)
Foley Care
Empty Foley Bag
Shave
Feeding
Safety Belt (if applicable)
Mechanical Lift (if applicable)

Review of the Home Health Aide & Personal Care Worker/Attendant/Aide Skills / Experience Checklist dated 12/28/15 revealed the following skills validation sections were blank:

Transfer Techniques
Other bath (select 1 or more) Shower, Sponge, or Tub
Toileting and Elimination
Handwashing
Oral Hygiene
Range of Motion (active - passive)

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L 615	Continued From page 79 An interview conducted on 5/20/16 at 12:00 PM with EI # 1 verified the above findings. 3. EI # 13, Hospice Aide was hired by the agency on 6/18/12. Review of the Home Health Aide & Personal Care Worker/Attendant/Aide Skills / Experience Checklist (Annual Skills Testing) dated 4/28/16 revealed the following skills validation sections were blank: Transfer Techniques Toileting and Elimination Shampoo An interview conducted on 5/20/16 at 12:00 PM with EI # 1 verified the above findings.	L 615		
L 625	418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section. This STANDARD is not met as evidenced by: Based on agency policy, medical record (MR) review, and interviews with agency staff it was determined the agency failed to ensure the Hospice Aide (HA) Assignment (HAA) was individualized to meet the specific needs of each patient for 6 of 12 records with HA services. This affected Home Visit (HV) # 1, MR # 4, MR # 13,	L 625		

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L 625	Continued From page 80	L 625		

HV # 3, MR # 3, MR # 5 and had the potential to affect all patients served by the agency.

Findings include:

Policy Hospice Aide Services
Revised 7/18/14

Hospice Aide Services
2. Hospice aide services will be included in routine care on an intermittent basis when personal care is needed as identified by the IDG (Interdisciplinary Group). Services provided by a Hospice Aide include bathing, shampoo, range of motion activities, dry dressing changes, assisting the patient to the bathroom, use of commode or bed pan, assisting with meal preparation, feeding the patient, light housekeeping, and/or linen changes. These activities, in accordance with the IDG Plan of Care and physician's orders, will be assigned and supervised by a Registered Nurse.

1. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2).

Review of the MR revealed the patient was bed bound and unable to turn and position, incontinent of bowel and bladder, and dependent on 5 of 6 ADLs (Activities of Daily Living).

Review of the HAA dated 3/14/16 revealed a Partial Bath every visit was assigned and the visit frequency was 5 times per week. There was no documentation of why a complete bath was not required for the bed bound and dependent

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KINDRED AT HOME HOSPICE-MOBILE	**2800 DAUPHIN STREET, SUITE 103 MOBILE, AL 36606**

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L 625	Continued From page 81 patient. Further review of the HAA revealed no documentation of the patient's code status. An interview was conducted on 5/20/16 at 11:00 AM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, who verified the HA does a complete bath and the HAA was not updated and confirmed the patient code status was not on the HAA. 2. MR # 4 was admitted to the agency on 4/12/16 with diagnoses including Heart Failure Unspecified, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease. Review of the HAA dated 4/12/16 revealed the patient was on oxygen at 3.5 L/min (liters per minute). Review of the physician's orders revealed an order for oxygen at 4 L/min. An interview was conducted on 5/20/16 at 12:40 PM with EI # 3, MCP # 3, who confirmed the order for Oxygen at 3.5 L/min on the HAA was not correct. 3. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor. Review of the HAA dated 4/12/16 revealed an assignment for the HA to assess pain every visit and call the office if the pain is above 3. Review of the MR revealed the patient is non-verbal and unable to make needs known.	L 625		

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L 625	Continued From page 82	L 625		

An interview was conducted on 5/20/16 at 11:35 AM with EI # 6 who confirmed the above findings.

4. HV # 3 was admitted to the agency on 5/13/16 and recertified on 4/24/16 to 6/22/16 with admitting diagnoses of Cerebral Vascular Accident (CVA) with Cognitive Deficits Following CVA.

Review of the skilled nurse (SN) visit notes in the MR the patient was completely bed bound and lower extremities were stiff and and difficult to manipulate. The patient remains in bed 24 hours a day and requires extensive assist with 5 of 6 ADL's.

Review of the HAA sheet dated 4/19/16 revealed the RN assigned a partial bath for the patient instead of a complete bed bath. Further review of the MR revealed the HAA sheet was not individualized to the patient's specific needs.

An interview was conducted on 5/20/16 at 12:50 PM with EI # 5, MCP # 5, who confirmed the above mentioned findings.

5. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive.

Review of the HA frequency of visit on the HAA sheet dated 4/22/16 the HA was to visit 2 times a week. On 4/25/16 a physician order was written for the frequency of visit for the HA frequency to change to 5 times a week, then on the IDG dated 4/28/16 the RN documented the HA frequency as 3 times a week for 1 week starting 4/22/16 then 5 times a week for 2 weeks starting 5/1/16. On the

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L 625	Continued From page 83 Interdisciplinary Group (IDG) meetings dated 5/12/16 the RN documented 5 times a week for 2 weeks starting 5/15/16. Review of the HHA sheet dated 4/22/16 revealed the frequency of visits for the HA was 2 times a week. Further review of the HHA sheet revealed the RN failed to update the HA frequency to meet the patient's needs. An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings. 6. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia. Review of the HAA sheet dated 4/4/16 revealed the frequency of visits documented by the RN revealed the HA was to visit 5 times a week. Review of the IDG meetings dated 4/14/16 and 4/28/16 revealed the frequency of visits for the HA was documented as 3 times a week and the documented change to 5 times a week occurred during the IDG meeting dated 5/12/16 and was to start 5/15/16. Review of the HA visit notes dated 4/4/16, 4/11/16 and 4/13/16 revealed the HA was visiting 3 times a week. Further review revealed the RN failed to ensure the frequency of visits for the HA was correct on the HAA sheet. An interview was conducted on 5/20/16 at 11:35 AM with EI # 2, who confirmed the RN failed to document the correct frequency of visits for the HA.	L 625		

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L 626	418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. This STANDARD is not met as evidenced by: Based on review of agency policy, medical record (MR) and interviews with agency staff it was determined the agency failed to ensure the Hospice Aide (HA) followed the Plan of Care in 9 of 12 records reviewed with HA services. This affected Home Visit (HV) # 1, MR # 4, HV # 3, MR # 3, MR # 5, HV # 2, MR # 1, MR # 11, MR # 9 and had the potential to affect all patients served by the agency. Findings include: Hospice Policy Manual Hospice Aide Services ... 2. Hospice aide services will be included in routine care on an intermittent basis when personal care is needed as identified by the IDG (Interdisciplinary Group). Services provided by a Hospice Aide include bathing, shampoo, range of motion activities, dry dressing changes, assisting the patient to the bathroom, use of commode or bed pan, assisting with meal preparation, feeding the patient, light housekeeping, and/or linen changes. These activities, in accordance with the IDG Plan of Care and physician's orders, will be	L 626		

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L 626	Continued From page 85 assigned and supervised by a Registered Nurse... 1. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Arteriosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2). Review of the Hospice Aide Assignment (HAA) dated 3/14/16 revealed the following tasks to be completed every visit: Partial Bed Bath, Comb Hair, Mouth Care, Apply Lotion, Reposition Patient, Assist With Dressing, Perineal Care, Make Bed, Straighten Room and Empty Trash. Review of the Hospice Aide Visit Note dated 4/8/16 revealed no documentation the aide completed the following assignments: apply lotion, reposition patient, make bed, straighten room and empty trash. An interview was conducted on 5/20/16 at 11:00 AM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, who verified the HA did not complete all the assigned tasks. 2. MR # 4 was admitted to the agency on 4/12/16 with diagnoses including Heart Failure Unspecified, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease. Review of the HAA dated 4/12/16 revealed pain was assigned in the vital sign section with instructions to call the office if the patient's pain was greater than 5. Review of the HA visit notes dated 4/14/16,	L 626		

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L 626	Continued From page 86 4/16/16, 4/21/16 and 4/23/16 revealed no documentation of the patient's pain level. Review of the HA visit notes dated 4/19/16, 4/21/16 and 5/3/16 revealed documentation the HA completed the following tasks, which were not ordered on the HAA: apply lotion, total care, change linen, make bed, straighten room, and empty trash. An interview was conducted on 5/20/16 at 12:40 PM with EI # 3, MCP # 3, who verified the HAA was not followed on the visits mentioned above. 3. HV # 3 was admitted to the agency on 5/13/16 and recertified on 4/24/16 to 6/22/16 with admitting diagnoses of Cerebral Vascular Accident (CVA) with Cognitive Deficits Following CVA. Review of the HAA sheet dated 4/19/16 revealed the HA was to complete the following tasks 5 times a week: Partial bed bath, shampoo hair, comb hair, mouth care, assist with dressing, clean/file nails, disposable briefs, apply lotion, activity - total care, reposition, total assist with feeding, change bed linens, make bed, straighten room and empty trash. Review of the HA visit notes dated 4/24/16, 4/26/16, 4/27/16, 4/28/16 and 5/2/16 revealed the HA failed to complete shampoo and comb hair. Review of the HA visit notes dated 4/26/16 the HA failed to complete assist with dressing, clean/file nails, change bed linens and make bed. Review of the HA visit note dated 4/27/16,	L 626		

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L 626	Continued From page 87 4/28/16, 4/29/16, 5/4/16, 5/5/16, 5/6/16, 5/10/16, 5/11/16, 5/12/16, 5/13/16 and 5/17/16 revealed the HA failed to complete total assistance with feeding, change bed linens and/ or make bed as ordered. Review of the HA visit note dated 5/18/16 revealed the patient had refused all care. An interview was conducted on 5/20/16 at 12:50 PM with EI # 5, MCP # 5, who confirmed the above mentioned findings. 4. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive. Review of the HAA sheet dated 4/22/16 the hospice aide was to complete the following tasks 2 times a week. Shower, shampoo hair, comb hair, mouth care, assist with dressing, Pullups, pads, perineal care, apply lotion, activity - walker, chair, bed, change bed linens, make bed, straighten room, empty trash. Review of all the HA visit notes dated 4/25/16 - 5/13/16 revealed the HA failed to complete activity of walker, chair and bed. Review of the HA visit note dated 4/27/16 revealed the HA documented the repositioning of the patient, which was not on the HHA sheet. An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings. 5. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular	L 626		

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L 626	Continued From page 88 Accident (CVA), Hypertension and Dementia. Review of the HHA sheet dated 4/4/16 the HA was to complete the following tasks 5 times a week. Complete bed bath, comb hair, mouth care, shave straight razor, assist with dressing perineal care, apply lotion, activity - wheelchair, chair, bed, total care, reposition patient, Hoyer lift, change bed linens, make bed, straighten room and empty trash. Review of the HA visit notes dated 4/11/16 and 4/13/16 the HA completed assist-bath-chair which was not on the HHA sheet. The HA failed to complete reposition patient, straighten room and empty trash. Review of the HA visit notes dated 4/26/16 and 4/27/16 the HA failed to complete change linens. Review of the HA visit note dated 5/3/16 the HA failed to complete shave or change bed linens. An interview was conducted on 5/20/16 at 11:35 with EI # 2, who confirmed the above mentioned findings. 6. HV # 2 was admitted to the agency on 1/27/15 with diagnosis including Senile Dementia. Review of the Hospice Aide Assignment sheet with the date of the first visit of 3/21/16 revealed the HA visit frequency was ordered 5 times a week and was assigned to perform a tub bath every Monday and complete bed bath on Tuesday through Friday and to assess for pain every visit. Review of the Interdisciplinary Plan of Care	L 626		

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L 626	Continued From page 89	L 626		

Continued From page 89
Review/Update dated 3/23/16 revealed no documentation of the Hospice Aide (HA) frequency of visit.

Review of the HA Visit Notes dated 3/22/16, 3/23/16, 3/24/16, 3/25/16, 3/28/16, 3/29/16, 3/30/16, 3/31/16, 4/1/16, 4/4/16, 4/11/16 and 5/16/16 revealed no documentation the HA assessed the patient for pain.

Review of the HA Visit Note dated 4/4/16 revealed the HA documented having performed both a shower and bed bath. The surveyor was unable to determine the type bath the HA performed.

Review of the HA Visit Notes dated 4/11/16 (Monday) and 5/16/16 (Monday) revealed the HA documented having performed a complete bed bath and not the ordered shower.

An interview was conducted on 5/20/16 at 10:00 AM with EI # 4, MCP # 4, who verified the above findings.

7. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer.

Review of the Hospice Aide (HA) Assignment dated 4/14/16 revealed the HA was assigned to visit the patient 3 times a week to provide personal care. The HA assignment included assessment for pain and to call the office with pain greater than 5.

Review of 14 of 14 HA notes from 4/18/16 to 5/16/16 revealed no documentation the HA assessed the patient for pain.

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L 626	Continued From page 90	L 626		

An interview was conducted on 5/20/16 at 10:10 AM with EI # 3, MCP # 3, who verified the above findings.

8. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia.

Review of HA Assignment dated 4/2/16 revealed the HA was to visit the patient 5 days a week beginning 4/4/16 to provide personal care. The HA assignment included assessment for pain, shampoo the patient's hair every visit, comb hair, perform mouth care and soak the patient's feet every visit.

Review of the HA Visit Note dated 4/4/16 revealed no documentation the HA shampooed the patient's hair.

Review of the HA Visit Note dated 4/5/16 revealed no documentation the HA assessed the patient for pain or soaked the patient's feet.

Review of the HA Visit Note dated 4/6/16 revealed no documentation the HA soaked the patient's feet.

Review of the HA Visit Notes dated 4/11/16 and 4/14/16 revealed no documentation the HA assessed the patient for pain.

Review of the HA Visit Note dated 4/19/16 revealed no documentation the HA assessed the patient for pain or shampooed the patient's hair.

Review of the HA Visit Note dated 4/20/16 revealed no documentation the HA assessed the patient for pain, shampooed the patient's hair or soaked the patient's feet.

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L 626	Continued From page 91	L 626		

Review of the HA Visit Notes dated 4/28/16, 4/29/16, 5/2/16, 5/5/16, 5/6/16, 5/9/16, 5/10/16, 5/11/16, 5/12/16 and 5/13/16 revealed no documentation the HA assessed the patient for pain.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5 who verified the above findings.

9. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer.

Review of HA Assignment dated 3/10/16 revealed the HA was to visit the patient 5 days a week, with the first visit to be conducted on 3/11/16 to provide personal care. The HA assignment included assessment for pain, provided a complete bed bath.

Review of the HA Visit Note dated 3/11/16 revealed the HA provided a shower. The HA failed to provide a complete bed bath.

Review of the HA Visit Note dated 3/14/16 revealed the HA was in the patient's home from 12:46 PM to 1:46 PM. There was no documentation of the care provided.

Review of the HA Visit Note dated 3/16/16 revealed the HA documented having performed a shower bath, bed bath and assist with a chair bath.

Review of the HA Visit Notes dated 3/18/16, 3/21/16, 3/23/16, 3/25/16 and 3/28/16 revealed the HA documented having provided a shower bath. The HA failed to provide a complete bed

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L 626	Continued From page 92 bath. Review of the HA Visit Note dated 3/30/16 revealed the HA documented the patient, "was not able to shower" and provided a bed bath. There was no documentation the HA notified the nurse of the findings. Review of the HA Visit Note dated 4/1/16 revealed the HA documented having provided a shower bath. The HA failed to provided a complete bed bath. Review of the HA Visit Note dated 4/4/16 revealed the HA documented the patient, "Pt (patient) not able to get in shower" and provided a bed bath. There was no documentation the HA notified the nurse of the findings. Review of the HA Visit Note dated 4/18/16 revealed the HA documented having applied lotion. There was no documentation the HA was assigned to perform this duty. An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.	L 626		
L 628	418.76(g)(4) HOSPICE AIDE ASSIGNMENTS AND DUTIES (4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.	L 628		

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L 628	Continued From page 93	L 628		

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This STANDARD is not met as evidenced by:
Based on review of agency policy, Hospice Aide Assignment sheet example, Hospice Aide Visit Note example, medical records and interviews with agency staff, it was determined the Hospice Aide (HA) failed to notify the Registered Nurse (RN) for changes in patient condition for 6 of 12 records reviewed with HA services, including MR # 1, MR # 9, Home Visit (HV) # 3, MR # 3, MR # 5, MR # 15 and had the potential to negatively affect all patients with HA services.

Findings include:

Hospice Policy Manual

Hospice Aide Services

... 2. Hospice aide services will be included in routine care on an intermittent basis when personal care is needed as identified by the IDG (Interdisciplinary Group). Services provided by a Hospice Aide include bathing, shampoo, range of motion activities, dry dressing changes, assisting the patient to the bathroom, use of commode or bed pan, assisting with meal preparation, feeding the patient, light housekeeping, and/or linen changes. These activities, in accordance with the IDG Plan of Care and physician's orders, will be assigned and supervised by a Registered Nurse...

Review of the Hospice Aide Assignment sheet example, which was given to the surveyors with the above policy revealed, "... Directions: Indicate assigned tasks by placing a check in the appropriate boxes, Provide specific instructions,

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KINDRED AT HOME HOSPICE-MOBILE	2800 DAUPHIN STREET, SUITE 103 MOBILE, AL 36606

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L 628	Continued From page 94 including frequencies. Assigned: A. Pain Ask the patient to rate their pain between 0 and 10 on each visit and report to the Hospice RN/MCP (Manager of Clinical Practice) pain that is greater than or equal to 3. If the patient cannot rate their pain, indicate that he/she is unable to report... M. Monitor Bowel Movement(s) (BM) (If no BM in 3 days, notify RN)... Q. Skin Care: Frequency:_____.... (if new wound/skin breakdown, notify RN)..." Review of the Hospice Aide Visit Note example, which was given to the surveyors with the above policy revealed, "This form is to be completed by the HA at the time of each pt (patient) visit... RN (name)... Notified of: You must report any changes in the pt, any refusal of service, lack of BM (bowel movement), etc... Other comments... Directions: Check box when task is completed; circle box if assigned task was not completed and explain in comments above. Notify RN of any change in patient, and document... A. Pain REMEMBER: If the pt reports a 3 or higher, you must report that to the RN & document above... M. Date of Last Bowel Movement __/__/__ (if no BM in three days or experiencing diarrhea, notify RN... Q. Skin Care... Notified RN of new wound/skin breakdown... You may only perform tasks that have been assigned 1. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer. Review of the HA Assignment dated 4/14/16 revealed the HA was assigned to visit the patient 3 times a week to provide a complete bed bath. Review of HA note dated 4/27/16 revealed the HA documented the patient did not want a bath, "was	L 628		

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L 628	Continued From page 95 weak." There was no documentation the HA informed the nurse that the patient was weak and refused a bath. Review of HA note dated 5/2/16 revealed the HA documented, "Call pt (patient) refused bath." There was no documentation the HA informed the nurse the patient refused a bath. An interview was conducted on 5/20/16 at 10:10 AM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 3, who verified the above findings. 2. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer. Review of HA Assignment dated 3/10/16 revealed the HA was to visit the patient 5 days a week, with the first visit to be conducted on 3/11/16 to provide personal care. The HA assignment included assessment for pain, provided a complete bed bath. Review of 7 of 8 HA Visit Notes dated between 3/11/16 and 3/28/16 revealed the HA provided a shower, which was not assigned by the RN and not reported to the RN. Review of the HA Visit Note dated 3/30/16 revealed the HA documented the patient, "was not able to shower" and provided a bed bath. There was no documentation the HA notified the nurse of the findings. Review of the HA Visit Note dated 4/1/16 revealed the HA documented having provided a shower bath, which was not assigned by the RN and not reported to the RN.	L 628		

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L 628	Continued From page 96	L 628		

Review of the HA Visit Note dated 4/4/16 revealed the HA documented the patient, "Pt (patient) not able to get in shower" and provided a bed bath. There was no documentation the HA notified the nurse of the findings.

An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.

3. HV # 3 was admitted to the agency on 5/13/16 and recertified on 4/24/16 to 6/22/16 with admitting diagnoses of Cerebral Vascular Accident (CVA) with Cognitive Deficits Following CVA.

Review of the HA visit notes dated 4/24/16, 4/26/16, 4/27/16, 4/28/16 and 5/2/16 revealed the HA failed to complete all tasks assigned by the RN.

Review of the HA visit notes and all the Communication Notes revealed no documentation the RN was notified in the change in the patient's Plan of Care (POC).

An interview was conducted on 5/20/16 at 12:50 PM with EI # 5, MCP # 5, who confirmed the above mentioned findings.

4. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive.

Review of all the HA visit notes dated 4/25/16 - 5/13/16 revealed the HA failed to complete all tasks assigned by the RN.

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L 628	Continued From page 97 Review of the HA visit notes and all the communication notes revealed no documentation by the HA to notify the RN in the change in the patient's POC. An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP #2, who confirmed the above mentioned findings, 5. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia. Review of the HA visit notes dated 4/4/16, 4/11/16, 4/13/16, 4/26/16, 4/27/16 and 5/3/16 revealed the HA failed to complete all tasks assigned by the RN. Review of the HA visit notes and all the communication notes in the MR revealed no documentation by the HA the RN was notified in the patient's change in the POC. An interview was conducted on 5/20/16 at 11:35 AM with EI # 2, who confirmed the above mentioned findings. 6. MR # 15 was admitted to the agency on 4/27/16 with an admitting diagnosis of Senile Degeneration of Brain Not Elsewhere Classified. Review of the HA visit note dated 4/29/16 the patient refused care and the HA was unable to complete all assigned tasks by the RN. Review of the HA note and all communication notes in the MR revealed the HA failed to notify the RN of the change in the patient's POC.	L 628		

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L 628	Continued From page 98 An interview was conducted on 5/20/16 at 12:15 PM with EI # 1, MCP # 1, who confirmed the above mentioned findings.	L 628		
L 629	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (I) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. This STANDARD is not met as evidenced by: Based on review of medical records (MR), agency policy and interviews, it was determined: 1. The Hospice Aide (HA) was not supervised by the Registered Nurse (RN) every 14 days. 2. The RN conducted HA supervisory visits prior to the initiation of HA services. This affected 2 of 12 records reviewed with HAs, including MR # 1, MR # 4 and had the potential to negatively affect all patients receiving HA services. Findings include: Hospice Policy Manual: Hospice Aide Services ... 3. The hospice aides are monitored by:	L 629		

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L 629	Continued From page 99	L 629		

RN supervision every 14 days at a minimum. If the Supervising Nurse identifies an area of concern, an on-site visit will be made. If the concern is validated, the Hospice Aide will complete the competency evaluation...

1. MR # 1 was admitted to the agency on 4/14/16 with Pancreatic Cancer.

Review of the Hospice Aide (HA) Assignment dated 4/14/16 revealed the HA was assigned to visit the patient 3 times a week to provide personal care.

Review of the medical record revealed the HA was visiting the patient three times a week to provide personal care. Review of the Nursing Clinical Notes revealed the HA was supervised by the RN on 4/18/16, then on 5/3/16, which was 15 days.

An interview was conducted on 5/20/16 at 10:10 AM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 3, who verified the above findings.

2. MR # 4 was admitted to the agency on 4/12/16 with diagnoses including Heart Failure Unspecified, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease.

Review of the Nursing Clinical Noted dated 4/13/16 revealed documentation the HA was supervised and was following the Plan of Care.

Review of the MR revealed the first HA visit was on 4/14/16.

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L 629	Continued From page 100 An interview was conducted on 5/20/16 at 12:40 PM with EI # 3, MCP # 3, who confirmed the RN documented supervision of the aide before the aide services began.	L 629		
L 643	418.78(a) TRAINING The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards. This STANDARD is not met as evidenced by: Based on review of volunteer files and interviews with the staff it was determined the agency failed to provide documentation showing all direct patient volunteers were trained in CPR (Cardiopulmonary Resuscitation) or American Heart Family and Friends course. This affected 3 of 13 direct patient volunteer files reviewed and had the potential to negatively affect all patients and volunteers served by the agency. Findings include: Review of 13 direct patient volunteer files revealed no documentation in 3 of the volunteer files of the volunteer attending a CPR class or the American Heart Family and Friends course. An interview was conducted on 5/20/16 at 11:50 AM with Employee Identifier # 14, Area Executive Director, who confirmed the above mentioned findings.	L 643		
L 644	418.78(b) ROLE Volunteers must be used in day-to-day administrative and/or direct patient care roles. This STANDARD is not met as evidenced by:	L 644		

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L 644	Continued From page 101	L 644		

Based on review of agency policy and procedure, medical records (MR) and interview with agency staff, it was determined the agency failed to ensure Volunteer Services were offered to each patient and family affecting 4 of 19 records reviewed affecting MR # 7, MR # 10, MR # 12 and MR # 13 and had the potential to affect all patients served by the agency.

Findings include:

Policy
02-18 Services Provided
Revised 07/18/2014

Volunteer Services

2. Patients and families admitted to hospice will be informed of the volunteer program. Upon completion of the Initial or Comprehensive Assessment, the patient and family will be evaluated as to the need or desire for volunteer activities.

1. MR # 7 was admitted to the agency on 1/14/16 with diagnoses including Pancreatic Cancer with Liver Metastasis.

Review of the Nursing Comprehensive Admission Assessment dated 1/14/16 revealed no documentation Volunteer Services were explained and offered.

An interview was conducted on 5/20/16 at 11:50 AM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, who verified there was no documentation that Volunteer Services were offered.

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L 644	Continued From page 102 2. MR # 10 was admitted to the agency on 4/1/16 with diagnoses including End Stage Renal Disease, Chronic Inflammatory Demyelinating Polyneuropathy, and Hypertension. Review of the Nursing Comprehensive Admission Assessment dated 4/1/16 revealed no documentation Volunteer Services were explained and offered. An interview was conducted on 5/20/16 at 12:30 PM with EI # 4, MCP # 4, who verified there was no documentation that Volunteer Services were offered. 3. MR # 12 was admitted to the agency on 4/1/16 with diagnoses including Congestive Heart Failure. Review of the Nursing Comprehensive Admission Assessment dated 4/1/16 revealed no documentation Volunteer Services were explained and offered. An interview was conducted on 5/20/16 at 12:15 PM with EI # 5, MCP # 5, who verified there was no documentation that Volunteer Services were offered. 4. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor. Review of the Nursing Comprehensive Admission Assessment dated 4/12/16 revealed no documentation Volunteer Services were explained and offered.	L 644		

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L 644	Continued From page 103 An interview was conducted on 5/20/16 at 11:35 AM with EI # 6, MCP # 6, who verified there was no documentation that Volunteer Services were offered.	L 644		
L 648	418.100 ORGANIZATIONAL ENVIRONMENT This CONDITION is not met as evidenced by: This Condition level deficiency was cited based on review of agency policies, medical records (MR), personnel files, Alabama Board of Nursing Administrative Code, Hospice Aide Assignment sheet example, Hospice Aide Visit Note example, volunteer files and interviews with agency staff, it was determined the Governing Body failed to ensure: 1. The Registered Nurse (RN) completed a comprehensive pain assessment for all patients. 2. Patients' Comprehensive Assessment Medication Profiles were up to date with the patients' current medications. 3. The Interdisciplinary Group was informed of changes in the patients condition and the patients' response to care. 4. The visit frequency was followed by each discipline providing care as established in the Plan of Care. 5. Teaching and education was provided to the caregivers as needed for wound care and newly ordered medication. 6. The Interdisciplinary Group developed an individualized plan of care, interventions or goals	L 648		

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L 648	Continued From page 104 for each patient, including psychosocial issues, pain, terminal diagnoses, wound care and tube feedings. 7. The plan of care included orders for wound care, Oxygen and laboratory testing. 8. The physician was notified with changes in patients' conditions. 9. The nursing staff failed to complete a comprehensive assessment for pain, nausea/vomiting and wounds. 10. The Hospice Aide (HA) was competent to provide care. 11. The HA Assignment was individualized to meet the specific needs of each patient. 12. The HA followed the Plan of Care. 13. The HA failed to notify the RN for changes in the patients' condition. 14. The HA was supervised by the RN every 14 days and the RN supervisory visits were not conducted prior to the initiation of HA services. 15. All direct patient volunteers were trained in CPR (Cardiopulmonary Resuscitation) or American Heart Family and Friends course. 16. Volunteer Services were offered to each patient and family. 17. The nursing staff documented complete and accurate assessments.	L 648		

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L 648	Continued From page 105 18. The clinical record included all Medication Pick Up and Delivery Forms. 19. Physician orders were put into writing in the MR. These deficient practices affected 19 of 19 MRs reviewed and had the potential to negatively affect all patients admitted to this agency. Findings include: Refer to L521, L530, L533, L543, L544, L545, L549, L557, L591, L615, L625, L626, L628, L629, L643, L644, L651, L672 and L678 for findings.	L 648		
L 651	418.100(b) GOVERNING BODY AND ADMINISTRATOR A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body. This STANDARD is not met as evidenced by: Based on review of agency policies, medical records (MR), personnel files, Alabama Board of Nursing Administrative Code, Hospice Aide Assignment sheet example, Hospice Aide Visit Note example, volunteer files and interviews with agency staff, it was determined the Governing	L 651		

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L 651	Continued From page 106 Body failed to ensure: 1. The Registered Nurse (RN) completed a comprehensive pain assessment for all patients. 2. Patients' Comprehensive Assessment Medication Profiles were up to date with the patients' current medications. 3. The Interdisciplinary Group was informed of changes in the patients condition and the patients' response to care. 4. The visit frequency was followed by each discipline providing care as established in the Plan of Care. 5. Teaching and education was provided to the caregivers as needed for wound care and newly ordered medication. 6. The Interdisciplinary Group developed an individualized plan of care, interventions or goals for each patient, including psychosocial issues, pain, terminal diagnoses, wound care and tube feedings. 7. The plan of care included orders for wound care, Oxygen and laboratory testing. 8. The physician was notified with changes in patients' conditions. 9. The nursing staff failed to complete a comprehensive assessment for pain, nausea/vomiting and wounds. 10. The Hospice Aide (HA) was competent to provide care.	L 651		

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L 651	Continued From page 107 11. The HA Assignment was individualized to meet the specific needs of each patient. 12. The HA followed the Plan of Care. 13. The HA failed to notify the RN for changes in the patients' condition. 14. The HA was supervised by the RN every 14 days and the RN supervisory visits were not conducted prior to the initiation of HA services. 15. All direct patient volunteers were trained in CPR (Cardiopulmonary Resuscitation) or American Heart Family and Friends course. 16. Volunteer Services were offered to each patient and family. 17. The nursing staff documented complete and accurate assessments. 18. The clinical record included all Medication Pick Up and Delivery Forms. 19. Physician orders were put into writing in the MR. These deficient practices affected 19 of 19 MRs reviewed and had the potential to negatively affect all patients admitted to this agency. Findings include: Refer to L521, L530, L533, L543, L544, L545, L549, L557, L591, L615, L625, L626, L628, L629, L643, L644, L651, L672 and L678 for findings.	L 651		

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L 672	418.104(a)(1) CONTENT	L 672		

Each patient's record must include the following:
(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.

This STANDARD is not met as evidenced by:
Based on review of agency policies and procedures, medical records (MR) and interview with agency staff it was determined the agency failed to ensure:

1. The nursing staff documented complete and accurate assessments.

2. The clinical record included all Medication Pick Up and Delivery Forms.

This affected 3 of 19 records reviewed affecting Home Visit (HV) # 1, MR # 13 and MR # 6 and had the potential to affect all patients served by the agency.

Findings include:

Agency Policy 02-18 Services Provided
Revised 07/18/2014

Policy
Nursing Services
1. Nursing services will be provided in accordance with accepted standards of practice by or under the supervision of a Registered Nurse (RN)...
4. The Hospice will ensure that the nursing services are sufficient to meet the healthcare

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needs of the hospice patient...
6. Direct provision of nursing care will be based on hospice nursing standards and clearly defined treatment protocols.

Agency Policy 03-21 Drug Delivery by Clinicians Revised 8/17/12

Policy:

Hospice employees will not routinely pick up, transport, or deliver medications from a pharmacy to a patient's home, another facility, or hospice program.

When there are cases of extreme emergency and medications cannot be delivered or picked up by a caregiver or designated representative, clinicians may transport medications.

In these instances, hospice clinicians will pick up and deliver sealed, non-tampered package and document by completing a Medication Pick Up and Delivery form (I-HOS3000). The Hospice clinician will obtain the pharmacy representative's signature and the patient or patient representative's signature on the Medication Pick Up and Delivery form.

Place the completed Medication Pick Up and Delivery Form in the patient's medical record.

1. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2).

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L 672	Continued From page 110 Review of the Nursing Clinical Note dated 3/17/16 revealed a narrative statement that the patient's BP (blood pressure) is elevated today. There was no documentation of the BP reading. An interview was conducted on 5/20/16 at 11:00 AM with Employee Identifier (EI) # 6, Manager of Clinical Practice (MCP) # 6, who verified the nurse failed to document the BP reading. 2. MR # 13 was admitted to the agency on 4/12/16 with diagnoses including Dysphagia Following Cerebral Infarction, Hypertension and Pituitary Tumor. Review of the Hospice Initial Order dated 4/12/16 revealed an order for a size 14 indwelling catheter. Review of the Nursing Comprehensive Admission Assessment revealed the patient had a size 14/10 foley catheter in place. Review of the Nursing Clinical Notes dated 4/13/16, 4/19/16, 4/22/16, 4/29/16, 5/6/16 and 5/13/16 revealed documentation the patient had a size 16 French foley catheter. An interview was conducted on 5/20/16 at 11:45 AM with EI # 6, who confirmed the nurses documented the incorrect size foley catheter. 3. MR # 6 was admitted to the agency on 4/15/16 with diagnoses including Malignant neoplasm of tonsilar fossa, Secondary malignant neoplasm of right lung, liver, intrahepatic bile duct and brain. Review of the Interdisciplinary Hospice	L 672		

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L 672	Continued From page 111 Communication - Pharmacy/DME (Durable Medical Equipment) note dated 4/17/16 at 8:45 PM revealed the RN documented having picked up medications from the pharmacy, delivered them to the patient and instructed on use. Review of the Interdisciplinary Hospice Communication - Pharmacy/DME note dated 4/17/16 at 9:00 PM, revealed the above mentioned RN documented having delivered (6) Dilaudid 4 milligram (mg) tablets, (6) Percocet 10 mg tablets and 50 milliliters (ml) Phenergan solution. There was no documentation of the Medication Pick Up and Delivery Form for the medications listed above. Review of the Interdisciplinary Hospice Communication - Phone Contact dated 4/20/16 at (undocumented time) revealed the RN documented the patient received two prescriptions for pain medications, one on 4/18 for 10 and it was delivered by on call personnel, another prescription on 4/19/16 for 20 pills of Norco 10. The RN documented she made another visit to the patient on 4/20/16 at 1:30 PM because he/she called stating was still hurting. The nurse documented she counted the medications at that time and the patient had 9 pills. The RN documented she received another call at around 4:00 PM from the patient's cousin, who stated the patient was completely out of medication. The RN documented, she had just left the patient and he/she had 9 pills left. There was no documentation of the Medication Pick Up and Delivery Form for the medications listed above. There was no documentation the SN visited the patient on 4/20/16.	L 672		

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L 672	Continued From page 112 An interview was conducted on 5/20/16 at 10:25 AM with EI # 5, MCP # 5, who verified the above findings.	L 672		
L 678	418.104(a)(7) CONTENT [Each patient's record must include the following:] (7) Physician orders. This STANDARD is not met as evidenced by: Based on review of medical records (MR), agency policy and interviews with the staff, it was determined the agency failed to ensure all physician orders were put into writing in the MR. This affected 8 of 19 MR reviewed and affected MR # 2, MR # 3, MR # 5 MR # 14, MR # 11, MR # 9, Home Visit (HV) # 1, MR # 4 and had the potential to negatively affect all patients served by the agency. Findings include: Policy: Physician's Orders Policy Number: 03-10 Revised Date: 12/14/15 Policy: 1. All care and treatment prescribed for a patient require an order signed by a physician. Verbal or written orders must be obtained prior to the provision of care requiring such orders... 1. MR # 2 was admitted to the agency on 4/12/16 with an admitting diagnosis of Alzheimer's Disease, Unspecified. Review of the Interdisciplinary Group (IDG) meeting dated 5/12/16 under the	L 678		

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Genitourinary/Lower GI (gastrointestinal) section the Registered Nurse (RN) documented the patient was started on a stool softer.

Further review of the IDG meeting dated 5/12/16 revealed no documentation of what stool softer was started. Review of all the physician orders revealed no documentation an order was written.

Review of the skilled nurse (SN) visit note dated 5/4/16 revealed the nurse documented in the narrative section of the note the nurse completed a rectal exam and attempted to remove an impaction. The SN also documented in the narrative section the patient's Lactulose was increased to 3 times a day.

Review of all the physician orders in the MR revealed no documentation an order was written for the rectal exam or removal of the impaction and no documentation an order was written to increase the patient's Lactulose to 3 times a day.

Review of the SN visit note dated 5/4/16, which is an on call note, revealed the nurse documented the patient was checked for an impaction and that the patient receives frequent enemas.

Review of all the physician orders in the MR revealed no documentation of a physician order for checking for an impaction or enemas.

Review of the SN visit note dated 5/5/16 revealed the SN documented the nurse performed a rectal exam and a mineral oil enema was given.

Review of all the physician orders in the MR revealed no documentation of an order for the rectal exam nor the mineral oil enema.

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An interview was conducted on 5/20/16 at 12:00 PM with Employee Identifier (EI) # 3, Manager of Clinical Practice (MCP) # 3, who confirmed the above mentioned findings.

2. MR # 3 was admitted to the agency on 4/22/16 with admitting diagnoses of Senile Degeneration of Brain and Failure to Thrive.

Review of the SN visit note dated 4/23/16 revealed the nurse documented in the narrative the patient could not sleep and the caregiver gave Benadryl.

Review of the MR revealed SN documentation the patient entered Respite Care on 5/9/16 and discharged on 5/13/16.

Review of all the physician orders in the MR revealed no documentation of orders for Benadryl or Respite Care.

An interview was conducted on 5/20/16 at 11:15 AM with EI # 2, MCP #2, who confirmed the above mentioned findings.

3. MR # 5 was admitted to the agency on 4/2/16 with admitting diagnoses of Cerebral Vascular Accident (CVA), Hypertension and Dementia.

Review of the SN visit note dated 4/5/16 in the narrative section of the note the SN documented Thick It was ordered to add to the patient's liquids.

Review of all the physician orders in the MR revealed no documentation an order was written for the Thick It.

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L 678	Continued From page 115 An interview was conducted on 5/20/16 at 11:35 AM with EI # 2, MCP # 2, who confirmed the above mentioned findings. 4. MR # 14 was admitted to the agency on 4/14/16 with an admitting diagnosis of Chronic Systolic (Congestive) Heart Failure. Review of the SN visit note dated 4/15/16 revealed the nurse documented in the narrative section of the note the wound care was complete. Vaseline and gauze were applied. Review of all the physician orders in the MR revealed no documentation an order was written for the Vaseline and gauze wound care. Review of the SN visit note dated 4/25/16 revealed the nurse documented the INR (International Normalized Ratio) was checked. Review of all the physician orders in the MR revealed no documentation an order was written to obtain the INR. An interview was conducted on 5/20/16 at 12:30 PM with EI # 6, MCP # 6 who confirmed the above mentioned findings. 5. MR # 11 was admitted to the agency on 4/2/16 with diagnosis of Parkinson's Dementia. Review of the Nursing Clinical Note dated 4/5/16 revealed the nurse documented having obtained INR via fingerstick. There was no documentation of a physician's order for the nurse to obtain the INR.	L 678		

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Review of the Physician Order dated "Late entry" for 4/8/16 revealed orders to cleanse stage 2 decubitus with wound cleanser, pat dry, cover with hydrocolloid. Caregiver to change once a week and as needed in absence of nurse. There was no documentation on the physician's order of the location of the stage 2 decubitus.

An interview was conducted on 5/20/16 at 12:25 PM with EI # 5, MCP # 5, who verified the above findings.

6. MR # 9 was admitted to the agency on 3/4/16 with diagnosis of Prostate Cancer.

Review of the Physician Order dated 3/10/16 revealed orders for Milk of Magnesia. There was no documentation of the dosage, route or frequency.

Review of the Interdisciplinary POC Review/Update dated 3/29/16 revealed new interventions for the skin tear to the patient's back were Bacitracin and non-stick dressing.

Review of the Nursing Clinical Note dated 4/2/16 revealed the nurse documented having performed wound care to the patient's skin tear to the mid-back as follows, "... wound cleansed and I placed vaseline gauze with 4 x 4 gauze with paper tape over it to avoid sticking..." The nurse failed to follow the POC utilizing Bacitracin and non-stick dressing. Further review revealed, there was no documentation of what the nurse used to cleanse the wound and no documentation of a Physician's order for the use of vaseline gauze.

Review of the Physician Order dated 4/4/16 revealed orders to cleanse skin tear to left hand

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with wound cleanser, pat dry, apply wound gel, cover with non-stick dressing, two times a week per SN (skilled nurse) or CG (caregiver).

Review of the Nursing Clinical Note dated 4/7/16 revealed the nurse documented having performed wound care to the patient's skin tear to the mid-back as follows, "... skin tear cleansed with wound cleanser, patted dry, applied wound gel, covered with non-stick dressing..." There was no documentation of a physician's order for the use of wound gel to the mid-back skin tear.

Review of the Interdisciplinary POC Review/Update dated 4/12/16 revealed, "... Plan: Continue same intervention(s)..." There was no documentation the POC had been updated to reflect the new skin tear to the left hand or interventions (Bacitracin and non-stick dressing {mid-back} - POC dated 3/29/16)

Review of the Nursing Clinical Note dated 5/9/16 revealed the nurse documented the patient had rhonchi to the right lung, notified the physician and orders were received for Duoneb nebulizer treatments three times a day. There was no documentation of a physician's order for Duoneb.

An interview was conducted on 5/20/16 at 10:50 AM with EI # 4, MCP # 4, who verified the above findings.

7. HV # 1 was admitted to the agency on 9/18/15 and recertified for 3/16/16 to 5/14/16 with diagnoses including Heart Failure Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Obstructive Pulmonary Disease, and Dependence on Supplemental Oxygen (O2).

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Review of the Physician's Order dated 4/13/16 revealed the following: Z-Pack and Medrol Dose Pack. There was no documentation of the strength, dose or quantity of the medications ordered.

An interview was conducted on 5/20/16 at 11:00 AM with EI # 6, MCP # 6, who verified the order was incomplete.

8. MR # 4 was admitted to the agency on 4/12/16 with diagnoses including Heart Failure Unspecified, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease.

Review of the Nursing Clinical Note dated 4/18/16 revealed documentation the patient had 2 episodes of diarrhea and had Imodium available if it continued.

Further review of the Nursing Clinical Note dated 4/18/16 and review of the notes dated 4/25/16 and 5/2/16 revealed the patient was using Oxygen at 3 L (liters) per n/c (nasal cannula).

Review of the Nursing Clinical Noted dated 5/9/16 revealed documentation the patient was using oxygen at 2 L per n/c.

Review of the all physician's orders revealed no order for the Imodium and no order to decrease the oxygen.

An interview was conducted on 5/20/16 at 12:40 PM with EI # 3, MCP # 3, who confirmed there was no order written for the Imodium nor the change in Oxygen.